STATE TITLE V BLOCK GRANT NARRATIVE
STATE: ID
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services and are available upon request.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Idaho contracted with Health Systems Research to conduct Idaho's 5 year needs assessment. This process included input from various organizations and individuals representing MCH populations. The process included written and phone surveys, focus groups and key informant interviews. See attached needs assessment. MCH funded programs involve public input as appropriate for program direction and implementation. For example, CSHP's ongoing effort to transition the program from a pay for service to a systems development and maintenance program. The program has coordinated numerous meetings with policymakers, advocates, health care providers and families to begin designing a system that will assure access to specialty health care for CSHCN. Public input will be solicited as we develop strategies to address the priority areas identified in the needs assessment.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and unhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

Population Information

The 1999 estimated population for Idaho is one million, two hundred fifty-one thousand, seven hundred (1,251,700). Idaho ranks 40th in the United States in population. The increase from 1990 to 1999 of 24.3% was the third highest increase in the nation, after Nevada (50.6 %) and Arizona (30.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.
/2004/ The 2001 estimated population for Idaho is 1,321,006.

/2005/ The 2003 estimated population for Idaho is 1,366,332. Idaho ranks 38th in the United States in population. The increase from 1990 to 2003 of 35.7% was the fifth highest increase in the nation. This population gives Idaho an average population density of 16.26 persons per square mile of land area. Seventeen (17) of Idaho's counties are considered "frontier."//2005//

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties. /2005/ 34.38 percent of the population in Idaho reside in the rural areas of the state.//2005//

/2005/ Summary of Population by Region (Health District) for 2000
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 250,984 19.40
District 2 100,533 7.77
District 3 191,297 14.78
District 4 344,355 26.61
District 5 162,397 12.55
District 6 156,906 12.13
District 7 160,132 12.38

/2005/ Summary of Population by Region (Health District) for 2003
(April 1, 2000 Census)

DISTRICT	POPULATION	PERCENT
District 1	265,672	19.44
District 2	100,348	7.34
District 3	213,465	15.62
District 4	369,002	27.01
District 5	167,444	12.26
District 6	158,266	11.58
District 7	168,969	12.37

//2005//

Ethnic Groups

The estimated racial groups that comprised Idaho's population in 1999 were: (a) white, 96.9%; (b) black, 0.60%; 8 native American/Eskimo, 1.33%; (d) Asian/Pacific Islander, 1.15%. Hispanics make up 7.4% of the race categories. More than half of Idaho's Hispanic population resides in two regions (health districts), with 32.5% residing in Health District 3 and 20.4% in Health District 5. The majority of the Native Americans reside on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

/2004/ Racial groups that comprised Idaho's population in 2000 were: (a) white, 91%; (b) black, .4%; (c) American Indian/Alaskan Native, 1.4%; (d) Asian, 0.9%; (e) Native Hawaiian/Pacific Islander, 0.1%; and (f) Other, 4.2%. Hispanics make up 7.9%.

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain. /2005/ A study of migrant and seasonal farm workers is currently being conducted. The report should be complete by Spring 2005. //2005//

Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1997-1999) median income in Idaho ($36,023) was 9.2% lower then the national average ($39,657). The number of children under 18 living in poverty varies greatly by county from the lowest (9.1%) in Blaine County to highest (31.2%) in Shoshone County. The statewide average is 16.5%. Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1997-1999), there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 53,000 of these children come from households that lack health insurance.

/2005/ Census data for 2000-2002 indicates there are approximately 393,000 children under the age of 19 living in Idaho. Approximately, 165,000 reside in households earning incomes at or below 200% of poverty level. It is estimated that 35,000 of these children come from households that lack health insurance.//2005//

Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96; and remained stable at 91.1% in the 1998-99 school year. Idaho's 1999 - 2000 school dropout rate among 16-19 year-olds dropped to 6 percent.

/2005/ Idaho's 2002-03 dropout rate among 16-19 year olds dropped again to 3.88 percent. //2005//

Health Delivery System in Idaho

As a rural state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance when planning a health care system. Serving distinct populations such as migrant/seasonal farm workers, children with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery is comprised of the following elements:

A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems.

B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.

C. In 2000, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,082. /2005/ Bed capacity has increased to 3,326.//2005//

D. There are 23 Community and Migrant Health Centers in Idaho which served 59,823 patients in 2000 with 213,241 encounters. There also are 35 certified rural health clinics, and 5 registered free medical clinics.

/2005/ There are 24 Community and Migrant Health Centers in Idaho which served 64,714 patients in 2002 with 234,101 encounters. There also are 43 certified rural health clinics, and 7 registered free medical clinics.//2005//

E. As of March 2001, there were 2,290 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 182 physicians providing patient care per 100,000 population. As of April 2001, there were 1,208 primary care physicians in Idaho. The ratio of primary care physicians per 100,000 population is 96.

/2006/ As of May 2005, there were 685 primary care practitioners licensed and practicing in

Idaho (these include practitioners who list Family Practice, General Practice, Obstetrics, Gynecology, Ob-gyn, Pediatrics and General Internal Medicine as their primary specialties.) There were a total of 308 Physician Assistants, 29 Certified Nurse Midwives, 441 Nurse Practitioners and 1,073 Pharmacists licensed and practicing in the state. It is also practical to note that there are 254 licensed Community Pharmacies in Idaho. There were 810 Physical Therapists, 297 Occupational Therapists (and 98 Occupational Therapy Assistants), 57 Psychiatrists and 687 Dentists licensed and serving Idahoans. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2006//

F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 2000. These clinics provide a wide variety of preventive health services to Native Americans.

G. Health Maintenance Organization (HMO) penetration rate for Idaho is estimated at 7%.

An area of concern facing Idaho is its aging health professional workforce. Ranked one of the "oldest" in the nation (second only to Wyoming), the state's population is growing at a much faster rate than the health care professional workforce in primary care. Doctors and dentists are retiring more quickly than medical graduates are replacing them. Idaho does not have a medical or dental school to contribute to this much needed workforce.

Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1997 - 1999, there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. Most of those children below 200% are covered by some form of health insurance; however, approximately 29.3% (53,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who did not have health insurance in 1998. According to FY 2000 BRFSS survey data, 13% of Idaho households contained uninsured children.

/2005/ An estimated 16.8% of the state's population, over 225,600 individuals, have no health insurance (age 18-64, 2002 BRFSS data.) That equates to 1 out of every 6 adults not having health care coverage.//2005//

Utilization of Medicaid is very low in Idaho compared to the rest of the nation. Less than 9% of Idaho residents are Medicaid recipients, compared to 12.6% of the U.S. population enrolled in Medicaid. Additionally, the 1998 Idaho State Child Health Plan Under Title XIX for the State Children's Health Insurance Program estimated that only about 60% of children eligible for Medicaid in Idaho are actually enrolled in the program.

/2005/ Many communities in Idaho, especially those in rural and frontier areas, are considered underserved. Idaho ranked 49th in the country in 2002 for number of primary care physicians per 100,000 civilian population. As of 2002, the ratio of primary care physicians per 100,000 population was 68. Currently 80.6% of the state's area has a designation as a health professional shortage area in primary care, 74.3% in dental health, and 100% in mental health (Figures 1, 2 and 3). Access to care in rural areas is especially variable. Providers are usually clustered in small communities but care for residents whose homes are scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel, health workforce recruitment challenges, deepening fiscal problems of rural health care facilities, as well as by fragile EMS
systems that often serve as first encounter points for direct care. Poverty level and low-income

populations face exceptional problems in accessing primary care. An estimated 16.8% of the adult population (age 18 to 64, 2002 Idaho BRFSS data) does not have health insurance, and even more are considered to have "insufficient coverage". An estimated 45% of Idaho adults age 18 to 64 do not have dental insurance (2002 Idaho BRFSS data). Other barriers include language, cultural, transportation and geographic factors.//2005//

/2006/ Currently, 88.4% of the state's area has a designation as a health professional shortage area in primary care, 88.7% in dental health, and 100% in mental health (Figures 1, 2 and 3).//2006//

The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. As a result, services such as those provided for reproductive health through contracts by the Title V agency are provided in only 37 (occasionally 38) of the 44 counties in Idaho. The counties without services are the most isolated and those with the lowest populations such as Camas county, population 844, and Clark county, population 906. Providing services to frontier counties that have clinic sites is challenging. For example, staff must travel from Idaho Falls (Bonneville County) to Salmon and Challis, Idaho, (Lemhi County) once a month to provide clinic services. This is a 368 mile journey that requires three nights of motel expenses, four days per diem expenses, and 7 to 10 travel hours. All travel is on two lane roads, and driving conditions are often hazardous in winter.

There are 23 community/migrant clinic sites in Idaho. All but one is in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. /2004/ There are now 2 community/ migrant clinics in north Idaho.

/2005/ There are 24 community/migrant clinic sites in Idaho. All but three are in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. There are now 2 community/migrant clinics in north Idaho.//2005//

/2005/During 2003, two new community/migrant dental clinics opened in southwest Idaho and a third added a dentist. In north Idaho, one such dental clinic has been expanded and efforts are underway to establish dental clinics at the two new community health centers. A mobile dental clinic, with 1-2 dentists providing care on-site has been operating in north Idaho in partnership with the District Health Department. During 2003, 7,600 patients were served via 18,000 dental visits at 7 on-site community health center dental clinics staffed by 7.5 FTE dentists. As of November 2003, there were 10.6 FTEs with 2 vacancies.//2005//

Oral Health

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. Through the Children's Health Insurance Program (CHIP) outreach efforts, 29,829 children have been enrolled in Medicaid and CHIP since November 1999, bringing the total to over 90,000 as of April 2001. These children will likely have poor access to dental services because in 1999, only 27.9 percent of the enrolled children had a dental visit or service. The picture does not get any brighter with an American Academy of Pediatrics' estimate that an additional 55,000 to 75,000 children in Idaho are medically uninsured. The Surgeon General's Report on Oral Health in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance.

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-three of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of March 2001, there were 709 active licensed dentists statewide. During state fiscal year 2000, the toll-free Idaho CareLine averaged 388 calls per month from persons seeking a Medicaid dentist. From July 2000

through February 2001, the CareLine received 4,061 calls for a Medicaid dentist and another 150 calls from persons seeking free or reduced fee dental services. In December 2000, CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 94 dentists responded that they were.

/2006/ During SFY 2004, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist, up 86 percent from 2003. Calls totaled 5,459 seeking a Medicaid dentist and 602 persons seeking free or reduced dental services.//2006//

/2005/ During state fiscal year 2003, the toll-free Idaho CareLine averaged 244 calls per month from persons seeking a Medicaid dentist. From July 2002 through June 2003, the Idaho CareLine received 2930 calls for a Medicaid dentist and another 431 calls from persons seeking free or reduced fee dental services. In April 2002, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 75 dentists responded that they were.//2005//

/2004/ During state fiscal year 2002, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist. From July 2001 through June 2002, the CareLine received 5,455 calls for a Medicaid dentist and another 293 calls from persons seeking free or reduced fee dental services. In April 2001, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 90 dentists responded that they were.

During federal fiscal year 2001, 122,526 children were enrolled in the combined Medicaid/ Children's Health Insurance Program (CHIP) and 29 percent had a dental visit or service. In FFY 2002, the number enrolled increased to 133,479, but the number of children who received any dental services decreased to 19 percent. According to the 2003 Idaho Kids Count Book, 28 percent of Idaho children under age 18 are without health insurance coverage, up from 18 percent in 1994, and an estimated 29,600 Idaho children under age 19 years are eligible but not yet enrolled in CHIP.

/2006/ During SFY 2004, the average monthly enrollment of eligible children in Title XIX Medicaid was 100,520 and 11,235 in Title XXI CHIP.//2006//

/2005/ The number of children insured through Medicaid and CHIP grew 154 percent between 2000 and 2003. In 2003, 33% of eligible children age 21 or younger and 21% of children age 1-5 years received a dental visit or service, an increase of 14% and 11% respectively over 2002.//2005//

As of June 2002, there were 767 active licensed dentists statewide, with 552 (72%) enrolled as Medicaid providers. Fifty percent were significant providers, receiving $10,000 or more in annual Medicaid payments. During state fiscal year 2002, the toll-free Idaho CareLine averaged 479 calls per month from persons seeking a Medicaid dentist or free/reduced fee dental services. From July 2002 through March 2003, the number of calls to the CareLine dropped to an average of 268 per month, reflecting public awareness that adult Medicaid dental benefits had been reduced to emergency care only. CareLine staff periodically calls each Idaho dentist with an active license to determine if they are accepting new Medicaid patients. As of March 2003, 11 of 44 counties had no dentists accepting new Medicaid patients and 7 counties had no dentists who accept Medicaid.

/2005/During 2003, there were 772 dentists and 769 dental hygienists with an Idaho license and in-state address. Ninety-one percent (705) of dentists were enrolled as Medicaid/CHIP providers, but only 59% (413) had one or more paid Medicaid claims in 2003. Dentists with paid Medicaid claims > $10,000 numbered 182 (26%); 11 of 44 counties had no dentists in this category. Currently, 30 of Idaho's 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area.
//2005//

/2006/ As of July 2004, there were 807 active licensed dentists with Idaho addresses; 563 (69.8%) dentists had at least one paid Medicaid claim and 319 (39.5%) had paid claims >

$10,000, a substantial increase over 2003. Four of the 44 counties had no enrolled Medicaid dentist. //2006//

Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services. We continue to pursue an enhancement of Medicaid for family planning services, which will reduce unintended pregnancy and improve the well being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births. No decision has been made to date. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program (CSHP). We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

/2005/ We are no longer pursuing TANF funds for family planning activities. We are working to expand options under Medicaid to allow coverage for family planning services for two years postpartum for women to improve preconception health and assure adequate spacing of births.//2005//

The Idaho Children's Health Insurance Program, CHIP, was implemented in October 1997 as a Medicaid expansion to take advantage of federal matching funds targeted to making health insurance available for uninsured children in families with limited incomes. Federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's task force was appointed to study and make recommendations on the long-term design for the program. Their report was delivered to the Department in November 1998 for review and submission to the new Governor and Legislature.

In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering

committee to revisit the citizen's task force recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Bureau of Health Policy and Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21 recommendations to the oversight committee in September 1999. The oversight committee made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts.

At the writing of the 2001 MCH Block Grant application, the importance of outreach to CHIP enrollment had been recognized and was made a top priority in the regional offices as well as the central office. The Department of Health and Welfare's aggressive campaign to identify children eligible for CHIP resulted in identifying four times as many who qualify for Medicaid. After starting out slowly with just a few hundred children in 1997, CHIP participation skyrocketed over the next two years to more than 10,000 children. At the same time, the promotional effort had been credited with uncovering tens of thousands of new Medicaid participants. However, in an effort to curb the growth of the Medicaid budget, the State Legislature voted to cap the CHIP program as well as limit recruitment.

Analysts say the state would meet the federal promotional requirement by simply issuing a brochure. Ultimately, the legislature extended restrictions on promoting program participation to all state health and social service programs. How this mandate will impact program services remains to be seen.

Idaho's current Governor has declared this the "Generation of the Child", and in doing so, has established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24-month-old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with Scientific Technologies Corporation to develop a plan for the implementation of the immunization registry, the immunization reminder information system (IRIS). The registry is now operational and has been for over two years. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

/2003/ The number of providers providing vaccination data to IRIS increased to 100. To date there are over 139,814 patient records.

/2004/ The number of providers providing vaccination data to IRIS increased to 129. To date there are over 195,000 patient records and over 2,000,000 vaccination records. All but 43,667 of the vaccination records are for individuals 18 and younger.

/2005/ As of 6/10/04: 203 Health Care Providers, 554 Schools and Daycares are enrolled 220,316 patient records and 2,527,407 vaccinations. 162,514 records are 18 and younger, 57,802 are over 18.//2005//

/2006/ As of 6/10/05: 253 Health Care Providers, 758 Schools and Daycares are enrolled in IRIS. 265,228 patients total, 3,124,787 vaccinations. 190,712 records are 18 and younger, 74,516 are over 18.//2006//

Another recent initiative within the state is an effort to better coordinate health services to clients. This is exemplified by the vision statement of the Idaho Department of Health and Welfare's new "Strategic Plan 2001 - 2004" which is to Provide leadership for development and implementation of a

sustainable, integrated health and human services system. While the plan is obviously intended for the entire population of Idahoans, its vision, goals and objectives describe an approach consistent with the MCH needs assessment/performance measure model used in the current block grant. Every four years, the Department will collect and compile health and safety data, prioritize health and safety issues based on this data, and develop strategies, set expected outcomes measures and identify resources. Following that process, there will be an evaluation of the impact of strategies on improving the status of health and safety priorities. Other features of the plan call for identification of family and community resources necessary to support the wellbeing of Idahoans and identification and application of models of cooperative relationships to support an integrated and sustainable health and human services system.

/2004/ The Department is currently in the process of designing an Any Door initiative to ensure clients are linked with needed services. This will include all services offered by the Department of Health and Welfare and the public health districts as well as a referral system for services outside the scope of these agencies. The vision is to have a single enrollment form and navigator type position to help clients access services for which they are in need and for which they qualify. This is a large expansion from the MCH activities implemented within the past few years such as the immunization -- WIC linkage. As this model develops, a focus will be placed on a client-centered plan with specific goals including exit from public assistance. The target date to pilot the project is January 1, 2004.

/2005/ The Any Door Initiative has been piloted in one small office in health district 2 and is now being implemented district-wide. While the focus of this service integration project has been on the social services delivered through regional offices of the Department of Health and Welfare, coordination of service application and referral is occurring between the Department and the health districts. This will include common enrollment forms that will overlap to district delivered services such as WIC and CSHP and a navigation function that will assist clients in accessing public health services even though they are applying through a social service center.//2005//

/2005/ Idaho will be funding an obesity project this coming year with MCH funds from last year's grant. Not all funds were spent as planned because one time state funding was available to cover some of the MCH expenses. These funds will be administered by the WIC program and contracted to the district health departments. The health departments will provide training to physicians who care for children. The training will include: using body mass index (BMI) to identify children at risk for becoming overweight; importance of encouraging families to have meals together and engage in exercise (Bright Futures Materials); and to promote and support continuation of breastfeeding. An evaluation will be conducted by staff from the Immunization Program Quality Assurance Review Team to determine the use of BMI in physician offices. A follow-up will also be conducted among parents that volunteer to participate in the project to determine if they have changed their meal time habits and increased exercise.

Another project that is included in the FFY 05' budget proposal is a perinatal project. Currently, there is considerable anecdotal evidence indicating poor birth outcomes among births attended by non-certified midwives. This project will be two fold: first to gather data on birth outcomes of deliveries attended by lay midwives and to begin education efforts to ensure expecting parents are aware of the benefits of working with qualified individuals to improve the opportunity to have healthy babies.

And the last new initiative is to fund a full-time research analyst located within the Division of Health's Bureau of Vital Statistics and Health Policy to work with MCH programs. The focus will be on developing and analyzing outcome measures for each of the MCH funded programs.//2005//

/2006/ Idaho is initiating a project to improve access to prenatal dental care, targeting low income women during their second trimester. This project will seek to achieve two goals, first is to increase referrals by obstetric providers, second to increase the number of pregnant women that actually receive dental services during pregnancy//2006//

Finally, as SFY 2001 drew to a close, the continuation of genetic laboratory and clinical services in

Idaho by the Bureau of Laboratories, became problematic. With the retirement of the Genetics Program Coordinator and the loss of a trained cytotechnologist, we were faced with the problem of recruitment of experienced individuals. At the same time we encountered budget problems with the operation of the Bureau of Laboratories.

In the face of these circumstances, we attempted to evaluate the status and future of the Genetics Program. To assist us, we consulted on several occasions with one of our Board Certified Geneticist consultants and his associates. This came on the heels of indications that one or both of our local regional medical centers had an interest in establishing both genetic clinical and/or laboratory capability. Due to a lack of medical geneticists in the state, we explored the prospect of recruiting and sharing a trained individual with one or both hospitals. After those discussions, it became clear that any such opportunity was not likely to take place in the near future. As a result, a decision was made to reorganize the Genetics Program, leaving the laboratory activities in place at the Bureau of Laboratories and transferring the newborn screening and the genetics clinic activities to the Bureau of Clinical and Preventive Services, the Title V agency.

/2004/ The previous program manager for the Genetics and Newborn Screening Programs resigned this past spring. At that same time the Department has been requested to cut 117 positions. The Program Manager position remains vacant and we are uncertain at this time when we will be able to fill it. Anne Spencer, a Masters level genetics counselor, continues to serve as a point of triage for clinical services, providing specialty consultation to health care staff, compiling family history, reviewing medical records, assessing risk and providing counseling to individuals and families.

/2005/ Brett Harrell, Manager of the state CSHCN Program, is now responsible for managing genetics and newborn screening. This was a natural fit since many of the children served through the genetics program and those diagnosed through newborn screening fall within the federal definition of CSHCN.//2005//

/2004/ Another significant change in the area of genetics coming in September 2003 will be a new pediatric endocrinologist at St. Luke's Hospital in Boise Idaho. This will greatly reduce the current backlog of patients seen at the Department's genetics clinics and provide opportunities for the program to focus on education activities. And lastly, as a result of a General Fund reduction, the state Newborn Screening Program was required to change their rules. The new rules, which were approved by the 2003 legislature, include a fee for service structure and mandates screening for 5 metabolic conditions. Idaho currently tests for over 24 conditions via tandem mass spectrometry at the state contract lab, Oregon Public Health Laboratory.

/2005/ Dr. Alex Karmazin, Pediatric Endocrinologist, is on staff with St. Luke's Regional Medical Center as planned and all endocrinology patients previously served by state staff will be transitioned to Dr. Karmazin by October 1, 2004. All new patients are referred direct.

The Newborn Screening Program recently expanded newborn screening testing to include hemoglobin disorders and Congenital Adrenal Hyperplasia.//2005//

Current MCH Priorities

A reexamination of health priority areas was conducted in May 2001, using an abbreviated needs assessment process. Division of Health and District Health Department representatives reviewed health status data and current program expenditures. Program staff provided summaries and proposals for continued and new activities.

Issues were prioritized based upon these criteria: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amenable to intervention/intervention proven effective by research. This process reaffirmed Idaho's areas of need identified in the five-year needs assessment and focused MCH activities during FY 2002 to impact these issues. The ten areas identified are:

Infant mortality and low birth weight
Adolescent pregnancy
Vaccine preventable diseases
Injuries
Substance and physical abuse
Investigation and control of "clusters" of reportable diseases and conditions
Prenatal care utilization
Children's access to health care coverage
Risky behavior in adolescents
Increased data capacity

B. AGENCY CAPACITY

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Ryan White CARE Act, Title II), immunization, WIC, programs for children with special health care needs, the SSDI position and grant, and most recently the newborn metabolic screening program and genetics clinics. The chief of BOCAPS provides additional fiscal oversight and program review for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services, Bureau of Health Promotion, Bureau of Health Policy and Vital Statistics and Division of Family and Community Services are included with this submission (Figures 4, 5, 6, 7, 8 and 9). ***/2006/ Bureau of Health Promotion is now the Bureau of Community and Environmental Health. //2006//***

/2005/ Two new programs were added to the Bureau of Clinical and Preventive Services; Worker Health and Safety and Women's Health Check. Worker Health and Safety is a program focused on reducing injuries to Department of Health and Welfare employees and does some consultation to the general public. Womens Health Check is the Idaho Breast and Cervical Cancer Screening Program. Also, the Bureau of Health Promotion is now called the Bureau of Community and Environmental Health.//2005//

/2006/ A new program was added to the Bureau of Clinical and Preventive Services to support the Division of Health's information technology programs including WIC's data base, the Immunization Registry, Health Alert Network, and the National Electronic Disease Surveillance System. This program's primary function is a help desk and to also assist with managing system upgrades and maintenance. //2006//

/2003/ Responsibilities for the Child Mortality Team have been transferred to the Bureau of Emergency Medical Services during state fiscal year 2002.

/2004/ As of January 2003 epidemiology services are now provided through the Office of Epidemiology and SSDI operates out of the Bureau of Health Policy and Vital Statistics.

/2004/ In an effort to coordinate MCH programs divided among the various offices, bureaus and divisions, quarterly meetings are held among all MCH funded programs as well as others such as WIC and substance abuse who are directly involved with providing services to the MCH population. Each meeting has a set agenda established by the MCH director with input from meeting participants. Based on comments provided during last year's review, the meeting functions have changed. They still include information sharing, but added to each meeting are planning discussions. For example, during our most recent meeting, a discussion was facilitated by the Asthma program manager to

determine how multiple MCH programs can work together to most efficiently serve our clients. Another phase of the discussion included planning for addressing obesity among the MCH population. Input was gathered from the meeting participants and an action plan will be developed among the specific programs targeted to initiate this collaborative effort.

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." He/she serves on the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2010 (HP) objectives for the nation.

Bureau of Clinical and Preventive Services (BOCAPS)

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. That portion of the Bureau's mission, related to maternal and child health, fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

Newborn Screening Program

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." The current newborn test battery includes screening for congenital hypothyroidism, galactosemia, maple syrup urine disease (MSUD), and biotinidase deficiency, in addition to PKU.

/2003/ The 2002 Legislature discontinued state fiscal support for the Idaho Newborn Screening Program with the start of state fiscal year 2003. With support from community organizations, such as the Idaho Medical Association, the Idaho Hospital Association, the Idaho Perinatal Project, and the Idaho Chapter of the American Academy of Pediatrics, Division of Health leadership instituted a fee for the Newborn Screening Program, effective July 1, 2002.

/2004/ This new fee structure was approved by the 2003 State Legislature. The impact of this new structure has been to increase the number of conditions diagnosed through the program. Since Oregon Public Health Lab has been providing screening services and physician consultation for decades, this change was transparent at the provider level other than the new fee structure. We continue to see a high rate of testing among our infant population with less than two percent not being tested, opting out for religious or personal reasons.

/2005/ Two new tests were added to the newborn screening program this past year. They include hemoglobinopathies and Congenital Adrenal Hyperplasia.//2005//

Children's Special Health Program

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

/2005/ The CSHP program manager is now administratively responsible for overseeing the state newborn screening and genetics programs.//2005//

/2006/ CSHP rules were revised during the 2005 legislative session. The most significant change was to change eligibility criteria. Previously the program was open to children meeting

certain diagnostic criteria regardless of insurance status. The rules have been revised to limit program services to uninsured children only. //2006//

The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

/2003/ Roger Perotto retired as of August 2001. Russell Duke, M.S., became the Chief of the Bureau of Clinical and Preventive Services in June of 2002. He was Acting Chief of the Bureau of Clinical and Preventive Services from December 2001 through his permanent appointment. His prior position was Chief, Bureau of Environmental Health and Safety.

Susan E. Ault, B.S.N., R.N., A.R.N.P., has been the Family Planning Program Manager since 1988. This program has been re-named the Reproductive Health Program. Ms. Ault has also served as a provider of family planning services, school nurse and public health nurse for thirteen years prior to her appointment within the Bureau.

/2006/ Susan Ault has resigned her position and will be working with the Idaho Primary care Association. Her position is presently open for new applicants.//2006//

Christine Hahn, M.D., has been the State Epidemiologist since February 1997. Dr. Hahn is funded 0.5 FTE through the MCH Block Grant. She provides epidemiological support and consultation to all Title V programs and currently provides staff leadership to the Child Mortality Review Team.

/2004/ Dr. Hahn continues to provide consultation to all Title V programs in combination with the Deputy State Epidemiologist, Leslie Tengelsen. While support levels remain the same, funding is actually going to .3 of Dr. Tengelsen's salary and no support of Dr. Hahn's salary.

Leslie Tengelsen, Ph.D., D.V.M., has been the Assistant State Epidemiologist since 1998. She also provides epidemiological support and is currently involved in providing data analysis for the Bureau of EMS in assessing emergency response capability for pediatric patients as part of an MCH EMSC grant.

/2003/ Drs. Hahn and Tengelsen are in the newly created Office of Epidemiology and are not a part of the Bureau of Clinical and Preventive Services.

/2005/ Jared Bartschi, Health Program Specialist in the Office of Epidemiology and Food Protection, is responsible for HIV/AIDS and STD surveillance and epidemiology, and other projects as assigned.//2005//

/2005/ Brett Harrell, B.S.W., M.A.T., was appointed Manager, Children's Special Health Program, in May 1995, after serving as the Director of Special Projects since November 1994. He was also given managerial responsibility for the newborn screening and genetics programs in the fall of 2004. Mr. Harrell has more than twenty years of experience in administration and management, which has included directing a regional hospice organization and a statewide diabetes association.//2005//

Judy Peterson, M.S., R.D., L.D., provides nutrition consultation to the Children's Special Health Program for PKU clients as well as other nutrition related issues. She also works with the Idaho WIC Program.

/2004/ Judy Peterson, resigned in July of 2002, but continues to provide nutrition consultation to CSHP for PKU clients through her part time employment with St. Luke's Regional Medical center, a contractor of CSHP. Her position in WIC was refilled, but has not yet been used for PKU consultation. This may take place during the course of the coming year.

Emily Geary, M.S., R.D., L.D., has worked as the Nutrition Education Coordinator for the Idaho WIC

Program since 1998. Ms. Geary serves as a consultant for metabolic conditions impacted by nutrition, for obesity initiatives, and began providing consultation to CSHP in 2004 for children with PKU and other metabolic conditions.

/2006/ Emily Geary transferred from the WIC program to the Breast and Cervical Cancer Screening Program. Jean Heinz was hired in her place. Ms. Heinz has over 20 years of experience as a Registered Dietitian and most recently worked for the Idaho State Department of Education, Child Nutrition Programs.//2006//

Linda Morton, M.P.H., R.D., L.D., I.B.C.L.C., has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 1993. Ms. Morton has over 20 years of varied work experiences in public health and is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.

/2005/ Linda Morton is working with the Department's Any Door Initiative and Cristi Litzsinger, R.D., L.D., I.B.C.L.C., is serving as the State Breastfeeding Promotion and Outreach Coordinator for the WIC Program. Cristi has 7 years of experience working as a WIC Nutritionist.//2005//

/2006/ Linda Morton has resigned from the Department of Health and Welfare. Cristi Litzsinger was hired in her place. Ms. Litzsinger has 8 years experience working in WIC and is an Internationally Board Certified Lactation Specialist.//2006//

Christina Giso, M.B.A., is Idaho's current MCH State Systems Manager (formerly designated the State Systems Development Initiative Coordinator) and the new Genetic Services Program Coordinator. Her advanced degree is in health systems administration, and her primary focus has been the MCH block grant needs assessment and performance and outcome measures. Currently, she serves as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

/2003/ Christina Giso is responsible for the Idaho Newborn Screening Program and the Genetic Services Program. She is no longer the AMCHP State Data Contact.

/2004/ Christina Giso resigned in April of 2003. The position is currently vacant and may not be filled pending Full Time Employee (FTE) reductions in the department. If the position is eliminated, the responsibilities will be transitioned to CSHP.

Bureau of Health Promotion

/2005/ Name changed to the Bureau of Community and Environmental Health.//2005//

Ginger Franks, Dr.P.H., has been the Injury Prevention Program Manager since 1996. She was a public health microbiologist in the California system before coming to Idaho. Her program is focusing on motor vehicle safety and sexual assault prevention, collaborating with the Departments of Transportation and Law Enforcement.

/2005/ With the strengthening of Idaho's adult safety restraint law in July 2003, the program objective addressing adult safety restraints was dropped. In 2005 we will be working to move the child safety restraint program to state and local partners. State partners will include Idaho Transportation Department and AAA-Idaho.//2005//

/2003/ Ginger Floerchinger-Franks, Dr.P.H. Her program is focusing on motor vehicle safety, bicycle safety, pedestrian safety, and teen rape prevention, collaborating with the Department of Transportation. Additionally, Dr. Franks is the coordinator for the Preventive Health & Health Services Block Grant and the Principal Investigator for the Rape Prevention Education Grant.

/2005/ The (Unintentional) Injury Prevention Program is changing focus by beginning to work with the elderly population. Current objectives focus on developing a network of exercise classes working on prevention falls and transitioning the child car safety seat program to other partners.

Kaili McCray has taken the lead for the Sexual Violence Prevention Program and is acting as Unit Manager for the Injury and Violence Prevention Unit. Although Ginger remains Idaho's coordinator for the Preventive Health and Health Services Block Grant, Kaili is the Principal Investigator for the Rape Prevention Education Grant.//2005//

/2004/ Injury Prevention Program's role has enlarged to include elderly fall prevention and suicide prevention. Kaili McCray, Ph.D., has been hired as the Manager for the Rape Prevention Education Program and is the Principal Investigator for the Rape Prevention Education Grant.//2004//

/2003/ Shelli Rambo-Roberson has replaced Angela Wickham as the Adolescent Pregnancy Program Manager. Shelli has a BS in Social Work and a BA in Education and has been the Adolescent Pregnancy Prevention Manager since last September. Her program is abstinence based and she works in collaboration with the seven health districts to offer community and school programs; the Idaho Governor's Council on Adolescent Pregnancy Prevention to provide a statewide media campaign; and other community programs to offer mini-grants that support youth asset building and pregnancy prevention at the local level.//

/2006/The Adolescent Pregnancy Program has been transferred to the Governor's Office.//2006//

Lisa Penny, B.S., R.D.H., has been Oral Health Program Coordinator since 1987. Ms. Penny has served within the Bureau since 1970, conducting school and migrant programs throughout the districts for seven years, and later directing educational and training activities as the state Dental Health Education Consultant. Ms. Penny has established a statewide program to promote oral health, increase use of preventive dental health measures, and improve access to dental care.

Office of Rural Health and Primary Care

Andrea Fletcher, M.P.H, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.

/2005/ Mary Sheridan, RN, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.//2005//

Laura Rowen, M.P.H., is the Primary Care Office Manager. Her role is to assess the state for areas of medical under service, barriers in access to health care, and identification of health disparities.

Bureau of Health Policy and Vital Statistics

Dianna Willis, M.A., has been the Perinatal Research Analyst (a.k.a. Senior Research Analyst) since 1998. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She was instrumental in conducting the Pregnancy Risk Assessment Tracking System (PRATS), and will be involved in conducting future surveys. Additionally, she has analyzed women's access to and utilization of prenatal care in Idaho, using Geographic Information Systems (GIS) technology. She has served as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP) and will soon be the MCH State Systems Manager.

/2003/ Dianna Willis is the current SSDI Program Manager for Idaho.

/2004/ Dianna Willis also serves as the State Data contract for the Association of Maternal and Child Health Program (AMCHP) and on the Advisory Board for the Idaho Perinatal Project.

/2006/ Dianna Willis recently resigned and the position is currently open for new applicants. //2006//

/2004/ Cory Reed is a Senior Research Analyst with a background in statistics and statistical computing that is working with MCH programs. Cory works with a variety of data sources to provide analytical support for MCH related activities including WIC, family planning services, and infertility prevention. Cory also has several years' experience using public health survey data including the Behavioral Risk Factor Surveillance System to analyze risk factors, chronic disease prevalence, and access to care issues that affect women's health.

/2005/ Cory Reed resigned and Greg Seganos has been hired in his place. Mr. Reed worked half time for MCH. Mr. Seganos works full time for MCH. //2005//

Division of Family and Community Services

Patricia Williams, is the Idaho CareLine Community Resource Coordinator for our toll-free referral service.

Public Health Districts

District health departments, who carry out implementation of state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, dental hygiene, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the masters level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, selected materials/supplies and funding for special projects. The main funding streams that complement Title V are county funds, fees, the State General Fund, Title X, Preventive Health and Health Services Block Grant, CDC's Immunization, HIV/AIDS Programs and the WIC Program.

C. ORGANIZATIONAL STRUCTURE

Statewide service delivery for the state agency is carried out by the public health districts and other non-profit and community based organizations through written contracts between the state and the agencies and organizations. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A description of the state agency programs and their capacity to provide services for each population group follows.

Pregnant Women, Mothers and Infants

The Reproductive Health Program (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women and infants and children through age 4 with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the program maintains a surveillance effort to record childhood immunization levels among two-year old

and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System.

The Newborn Screening and Genetics Services Program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. Additionally, clinic activities are provided through contracts with board certified medical geneticists for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing, available through the Idaho Bureau of Laboratories, and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided through these contractors to Idaho physicians and other health care professionals involved with all segments of the MCH population.

/2004/ Genetic testing is no longer available through the Bureau of Laboratories but is available through a St. Luke's/St. Alphonsus genetics lab.

/2005/ Pediatric Endocrinology clinics will discontinue effective September 30,2004. Since September of 2003 patients have been transitioned to a new pediatric endocrinologist practicing at St. Luke's Children's Hospital.//2005//

Children

/2005/ Note: The Bureau of Health Promotion is now the Bureau of Community and Environmental Health. However, the Women's Health Check Program is now with the Bureau of Clinical and Preventive Services. The Women's Health Check Program works together with health care and insurance providers, survivors, and health educators to move forward in the fight against breast and cervical cancer in Idaho.//2005//

The Bureau of Health Promotion administers the Title V programs of Oral Health, Adolescent Abstinence Grant, and Injury Prevention. The non-Title V programs include several preventive health education programs: arthritis, diabetes and cancer control, i.e., tobacco prevention and breast and cervical cancer screening. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

The Oral Health Program contracts with the district health departments to perform surveys of oral health status, as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects, and school sealant projects.

The Abstinence Education Block Grant is administered from this bureau. Presently, the program has contracted with the public health districts to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that address adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Idaho Governor's Council on Adolescent Pregnancy Prevention, which is staffed by the bureau.

/2006/ Adolescent Pregnancy Prevention has been transferred to the Governor's Office.//2006//

The Injury Prevention Program provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

/2003/ The Injury Prevention Program works with state and local partners to provide health promotion campaigns and activities for universal use of motor vehicle safety restraints, bicycle safety, and pedestrian safety. Through the Rape Prevention Education Grant the program also addresses teen rape prevention.

/2005/ The Injury and Violence Prevention Unit work with state and local partners to develop and implement programs addressing child motor vehicle safety restraints, fall prevention for community-dwelling seniors aged 65 years and older, and rape and sexual assault prevention on college campuses.//2005//

/2004/ The Injury Prevention Program continues to provide child safety seats and installation education with MCH funds. Also, in April 2003, the Injury Prevention Program began working with the DHW Division of Family and Community Services, Mental Health Program, the Idaho Department of Education, and community groups (SPAN-Idaho based out of Boise State University) to develop a comprehensive statewide suicide prevention plan.

/2005/ The Injury Prevention program is working to transition the child safety seat distribution and installation education to state and community partners.//2005//

Children with Special Health Care Needs.

The Children's Special Health Program (CSHP) provides and promotes direct health care services in the form of family centered, community-based, coordinated care for children with special health care needs, including phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories including, neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

/2005/ In addition to CSHP, the program manager is responsible for newborn screening and genetics.//2005//

All MCH Populations

The State Epidemiologist provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. Additionally, the Deputy State Epidemiologist is engaged in providing data analysis and consultation to the Bureau of EMS to improve emergency response capabilities for pediatric patients. The EMS effort is being funded by an MCHB EMSC grant.

The STD/AIDS Program provides HIV prevention education activities as well as counseling and testing. It also distributes HIV/AIDS therapeutic drugs to eligible clients.

The toll-free telephone referral service, Idaho CareLine, provides information and referral service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

/2006/ The Idaho CareLine has been designated the 211 Call Center for Idaho. Callers can now access referrals for any health and human service issue by dialing 211 or 1-800-926-2588.//2006//

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducted a Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

/2003/ Beginning with the federal fiscal year 2002 MCH Block Grant, the Perinatal Data Analyst assumed responsibility for the State Systems Development Initiative (SSDI) Grant.

/2004/ The Perinatal Research Analyst will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP) and will serve on the Advisory Board for the Idaho Perinatal Project.

The Office of Rural Health and Primary Care is focused on improving services in rural and underserved areas.

D. OTHER MCH CAPACITY

All state level MCH funded personnel (with the exception of the genetics clinical personnel and the Child Mortality Review Team Coordinator (CMRT)) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Health Policy and Vital Statistics are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. Genetics clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the Bureau of Laboratories located on a separate state campus approximately three miles from the primary office building. The CMRT Coordinator's office is less than one block from central office. Distance does not deter joint collaboration, which occurs via periodic meetings, telephone, electronic mail, and FAX communication.

A 1.0 FTE Program Manager, a 1.0 FTE Special Projects Director, and 1.0 FTE clerical specialist staff the CSHP program. In addition, services for PKU and high-risk children not covered by other service providers (WIC or EPSDT) are coordinated through CSHP. A Nutrition Specialist provides 0.2 FTE technical support to CSHP to assure PKU and special nutritional needs are met.

/2006/ The CSHP Manager is responsible for the management aspects of the genetics program as well as for newborn screening. A full time administrative assistant and part-time genetics counselor coordinate genetic clinics, counseling, diagnosis and follow-up care to women, infants and children.//2006//

/2004/ The Newborn Screening and Genetics Program Manager resigned this past Spring. Plans to fill the position or transfer program responsibilities to CSHP are pending the decision on whether or not the agency will maintain the FTE.

A 1.0 FTE program coordinator and a 0.5 FTE secretary staff the Oral Health Program.

The 1.0 FTE MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Health Policy and Vital Statistics.

The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 4.0 FTE Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

/2006/ The CareLine is now supported by a 1.0 FTE Community Services Coordinator and 6.5 FTE Customer Service Representatives.//2006//

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health, Epidemiology, Immunization, Reproductive Health, and Genetics Services. Within the Bureau of Health Promotion programs receiving MCH Block Grant funds are: Injury Prevention and Oral Health Promotion. The Health Statistics section of the Bureau of Health Policy and Vital Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Council for the Deaf and Hard of Hearing receives funding via a contract with the Title V Agency, and the Idaho CareLine receives direct MCH block grant funding.

/2003/ The Office of Epidemiology was created in 2001 and reports directly to the Administrator of the Division of Health.

/2004/ The Immunization Program no longer receives block grant funds. The Bureau of Emergency Medical Services receives funds for the part time CMRT Coordinator position.

/2006/ The child mortality team has been disbanded. //2006//

There are a number of other programs within the Department of Health and Welfare that are tied in varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Health Promotion receives MCH funds via the Abstinence Grant. This has also been true of the Bureau of Emergency Medical Services which has received an MCH grant for children's injury surveillance. Also, the Health Statistics Program of the Bureau of Health Policy and Vital Statistics is now administratively responsible for the SSDI grant.

/2005/ Idaho's breastfeeding promotion and support initiatives receive MCH funds periodically.//2005//

In addition to having funding ties to MCH programs there are a number of other programs with the umbrella Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the STD/AIDS program; within the Bureau of Health Promotion: the Breast and Cervical Cancer Early Detection program, the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention programs; within the Bureau of Health Policy and Vital Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, and the Infant Toddler program.

/2005/ Breast and Cervical Cancer Early Detection program is now within the Bureau of Clinical and Preventive Services and known as the Women's Health Check Program.//2005//

/2006/ The Adolescent Pregnancy Prevention program is now with the Office of the Governor.//2006//

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This agency provides much of the important data used in program assessment including providing data on health insurance as well as that which defines access to care issues. Also, each of the seven District Health Departments have very strong ties to each MCH program through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

E. STATE AGENCY COORDINATION

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

Formal agreements exist between the Divisions of Health, Family and Community Services, and Medicaid. These agreements refer to relationships of the three divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, Early Intervention Services through the Infant Toddler Program, Special Education Services under the Individuals with Disabilities Education Act, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V (Maternal and Child Health Block Grant) Program, the Title X (Family Planning) Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating

MCH prevention activities into the Medicaid Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

/2004/ During FY 2002, the MCH Oral Health Program, Medicaid, and the districts worked together to obtain provider status to allow reimbursement for preventive dental services provided by dental hygienists employed by the districts.

/2005/ During FY 2003, the MCH Oral Health Program and Medicaid engaged in ongoing discussions regarding early childhood caries prevention and the potential for integrating oral health with primary medical care through the Healthy Connections managed care program. Idaho Medicaid will reimburse physicians, physician's assistants and nurse practitioners for fluoride varnish application for children age 21 and younger. //2005//

/2006/During FY 2004, legislation changing the Idaho State Dental Practice Act was enacted, creating an extended access endorsement for dental hygienists allowing preventive dental hygiene services to be provided under general supervision in public health settings and allowing retired dentists to provide clinical dental services on a volunteer basis in non-profit dental clinics. Medicaid analyzed the potential cost impact if direct reimbursement were allowed to extended access endorsed dental hygienists. Currently, only district health departments or other entities that employ a dental hygienist can receive Medicaid reimbursement./2006/

/2006/ Women's Health Check cooperates with the Divisions of Medicaid and Welfare to provide treatment for women diagnosed with breast or cervical cancer.//2006//

As indicated in the FY 1996 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

A formal agreement between Title V and the Title X Family Planning Program is unnecessary. These two federal programs jointly fund the Reproductive Health Program. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

Cooperation between the Reproductive Health Program (Title V addressing teens) and the STD/AIDS Program regarding the Infertility Prevention Program is documented in a file letter. The letter verifies a formal contractual agreement with the districts and the Bureau of Laboratories to provide STD testing. Both of these programs reside within the Bureau.

The Bureau of Clinical and Preventive Services enjoys a traditional as well as efficient collaboration with the Bureau of Health Promotion with the latter having once been an organizational component of the former. This bureau provides health promotion activities for injury prevention, adolescent pregnancy prevention, breast and cervical cancer prevention, tobacco prevention, oral health promotion, diabetes control, arthritis, and rape prevention. The Bureau of Health Promotion collaborates with the Title V agency to impact those performance measures dealing with suicide, adolescent pregnancy and protective sealants.

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated Idaho CareLine. This service is administered through the Division of Family and Community Services.

Interagency agreements are reviewed on a periodic basis, depending on the expiration date of an interagency agreement if there is one, and subject to the cooperative relationships that these cooperative agreements represent.

Councils, Coalitions, and Committees (State and Non-State Agencies)

In addition to the formal agreements mentioned above, the MCH program staff serve on many committees and advisory boards, including but not limited to:
a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Education Act (IDEA), Part C.
e) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
f) Healthy Child Community, an interdepartmental group interested in promoting the health and well being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.
g) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.
h) Idaho Breast and Cervical Cancer Alliance (IBCCA), dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring.
i) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the availability of state-of-the-art emergency medical care.
j) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
k) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children. /2005/ This group is no longer a functioning partnership. //2005//
l) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
m) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
n) Idaho Governor's Council on Adolescent Pregnancy Prevention.
o) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
p) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for date and acquaintance rape prevention.
q) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho with recommendations for preventing future child deaths. ***/2006/ This group is no longer active.//2006//***
/2004/
r) Terry Reilly Health Service Dental Advisory Committee, which provides guidance for funding,

volunteer networking and operation of the community health center dental clinics. ***/2006/ Committee no longer meets./2006/***
s) Idaho Dental Hygienists' Association Community Outreach Committee, which seeks to expand access to oral health services through community projects and partnerships organized and/or conducted by the local component dental hygiene societies.
t) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
u) Action for Healthy Kids is a statewide initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity.
v) Healthy Weight Steering Committee is a diverse group with an interest in nutrition and physical activity. This group applied for and received funding from the Office of Women's Health, Region X, to conduct focus groups with postpartum women on issues related to weight and a statewide meeting on the issue of obesity in Idaho.
w) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT Book and related efforts to track and promote the well-being of children in Idaho through research, education and mobilization strategies.
x) Friends of Children and Families Head Start Health Advisory Committee. /2006/
y) Association of State and Territorial Dental Directors Data Surveillance Committee. /2006/

Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: school health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

The Title V agency implements program strategies through contracts with the public health districts. Indeed, the core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Health administration and staff meet monthly with the Directors of the district health departments.

Federally Qualified Health Centers/Community Health Centers

The Office of Primary Care, formerly of the Bureau of Health Policy and Vital Statistics, has a cooperative agreement with the Idaho Primary Care Association to help expand access to primary care in Idaho. As the FQHCs and CHCs often represent the only health care available in rural areas, past agreements have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer. Additionally, the Immunization Program maintains contracts with several FQHCs to provide immunization status assessments of their clinics as well as identifying barriers to immunization.

/2005/ The Reproductive Health program has an MOU in place with Family Health Services, a Community Health Center in Twin Falls, to pilot providing contraceptives to low income women in rural clinic sites. //2005//

/2006/ The MOU between Family Health Services and the Idaho Reproductive Health Program is currently in place until January 2006 when progress will be re-evaluated. Success of this partnership has been demonstrated by the 717 clients seen in CY04. In the first quarter of CY05, Family Health Services reported 421 clients have been seen in their clinics for

reproductive health care. Eighty-two (82) percent of these clients reported incomes of less than 100 percent of the federal poverty level. An MOU is also in place between Southeastern District Health and Healthwest, a community health center, in Pocatello, Lava Hot Springs, and Downey, Idaho. Clinics in Lava Hots Springs and Downey serve an area with limited pharmaceutical services.//2006//

Universities

The Division maintains a relationship with all three of Idaho's universities. Past projects have included a survey of high-risk populations for the HIV/AIDS Program by the University of Idaho and a survey of medical providers for the Office of Primary Care by Boise State University. The State Epidemiologist collaborated with Idaho State University on a CDC grant to study efficacy of the pertussis vaccine in outbreaks in Idaho. That university has also been a contractor with the Immunization Program to conduct assessments of the immunization status of patients seen in physician offices throughout the state. In 1999, the Title V agency collaborated with the Institute of Rural Health Studies (IRHS) at Idaho State University to develop a grant application to impact on alcohol use in pregnancy. During FY 2000, the University of Idaho was under contract to provide services related to the newborn hearing screening consortium. Currently, the Immunization Program is contracting with Boise State University and Idaho State University to provide student interns to private immunization providers to assist with the implementation of patient reminder/recall systems for their immunization patients.

/2005/ The Immunization Program no longer contracts with these universities as this program is already implemented.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

#01 HEALTH SYSTEMS CAPACITY INDICATOR
The rate of children hospitalized for asthma (10,000 children less than five years of age).

Idaho does not have hospital discharge data available so we do not know the discharge rate for children or adults. To fill this gap, the Idaho Asthma Prevention and Control Program (IAPCP) is working with the seven local health districts to determine the feasibility of gathering emergency department and in-patient utilization data directly from hospitals statewide. IAPCP is working with the Agency for Healthcare Resources and Quality to develop nationally comparable surveillance dataset requests for data from the hospitals. It is also working with a Boise hospital to pilot an education and follow up protocol for all asthma-related emergency department and in-patient admissions. This pilot, if successful, will be shared with hospitals statewide.

In an attempt to address the known contributors to hospitalizations among children (lack of knowledge among care providers, lack of access to medications during school hours, environmental triggers, and in-appropriate diagnosis and treatment), IAPCP and its partners, American Lung Association, Idaho Department of Education, and School Nurses Organization of Idaho, are working with schools to increase awareness among and efficacy of school staff and has developed the School Asthma Management Model for Idaho (SAMMI) that was distributed to all schools in Idaho. SAMMI is an administrative, policy, and educational tool. IAPCP and its partners successfully passed legislation to allow children to carry their asthma inhalers and self-medicate while at school. The IAPCP and the American Lung Association are partnering to provide the Open Airways for Schools program statewide, and IAPCP and the Indoor Environment Program are providing Tools for Schools assessments statewide. Over 250 child care providers have been educated in the management of asthma, and approximately 50 health care providers statewide have been trained in the appropriate diagnosis and treatment of asthma. Additionally, IAPCP has trained over 300 Head Start staff and 200 Head Start parents in methods to decrease exposures to asthma triggers in the home.

While there is no way to know what impact these interventions may be having on hospitalization rates for children, they are all based on best practices, and can be assumed to have some level of affect.

#02 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Two problems have been noticed with EPSDT screenings: 1) Parents mainly bring their infant/child in for an appointment when the child is sick and 2) codes for EPSDT screenings are not always entered correctly. The Division of Medicaid is currently working on a project that educates parents and providers regarding well baby clinics, reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

#03 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

Two problems have been noticed with EPSDT screenings: 1) Parents mainly bring their infant/child in for an appointment when the child is sick and 2) codes for EPSDT screenings are not always entered correctly. The Division of Medicaid is currently working on a project that educates parents and providers regarding well baby clinics, reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

#04 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Available and included.

#05 HEALTH SYSTEMS CAPACITY INDICATOR
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Available and included.

#06 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

Available and included.

#07 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Medical providers conduct a dental screening, risk assessment, referral if indicated and apply fluoride varnish while the child is in their office during a well child visit. Medicaid is now reimbursing physicians and midlevel providers for topical fluoride applications. (See narrative under SPM #6.)

#08 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program."

Always 0 since CSHP only provides insurance coverage equivalent for children with no source of payment.

#09(A) HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

Described on form 19.

#09(B) HEALTH SYSTEMS CAPACITY INDICATOR #09(B)
The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

Described on form 19.

#09(C) HEALTH SYSTEMS CAPACITY INDICATOR
The ability of States to determine the percent of children who are obese or overweight.

Described on form 19.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Idaho's priorities for its MCH population continue to be based primarily on the results of the 5 year needs assessment conducted five years ago.

The health needs of pregnant women are: Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care. The indicators for pregnant women are focused around the following topics: Breastfeeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

The health needs of infants are: Child Abuse, Immunizations, Improving access to care and Disparities in infant mortality. Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic show that Idaho is doing a good job of screening infants. Indicators for infants are focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity.

The health needs of children are: Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease. Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available. Indicators for children are focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

The health needs of adolescents are: Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy. Indicators for adolescents are focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence, the school dropout rate, and the juvenile arrest rate for violent crimes.

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. Access to Care, however, is the highest priority need for this population. The other two issues considered are availability of specialty care and inadequate data. Indicators for Idaho's CSHCN population are focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

The Title V Maternal and Child Health Block Grant directly funds programs and support services to address most of the issues identified as priority areas for Idaho's MCH population. They include: Reproductive Health, Children's Special Health Program, Oral Health, Epidemiology Services, Genetics, Newborn Hearing Screening, Perinatal Assessment, Injury Prevention, Child Mortality Review Team, Suicide Prevention, MCH Research and Data Analysis, and the Idaho CareLine.

/2006/ Idaho has just completed it's 5 year needs assessment. A contractor, Health Systems Resarch, performed the needs assessment. The assessment included several meetings with key stakeholder, key informant interviews, focus groups, general and population specific surveys, review of secondary data and a capacity assessment among state level MCH personnel. Priority needs are listed in the next section. //2006//

B. STATE PRIORITIES

1. To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services.
2. To reduce the adolescent pregnancy rate through improved access to contraceptive services.
3. To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents.
4. To increase access to care including oral health - (not limited to focusing on health insurance) - targeting women, infants and children and children with special health needs.
5. To increase prenatal care utilization focusing on population disparities.
6. To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age.
7. To reduce morbidity/mortality due to injury.
8. To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STD's.
9. To reduce infant morbidity/mortality by review of infant/child deaths by the Child Mortality Review Team, followed by targeted interventions.
10. To increase capacity for "cluster" investigation/surveillance and to increase data capacity for all MCH populations.

/2006/ Below is a list of priority areas that were identified during Idaho's 5 year MCH needs assessment. They are not in order of priority, but rather a list of the 10 key areas needing attention.

Priorities:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for pregnant women and children across provider and community networks.

2. Perinatal Depression: Identify screening tools and work with state professional groups and the regional perinatal coalitions to develop mechanisms to assure appropriate use of the tools and availability of referral resources for perinatal depression.

3. EPSDT screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring as appropriate for all infants, children and adolescents.

4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.

5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex care needs of all CSHCN.

6. Cultural Competency: Improve cultural competency across all programs that work with the Maternal and Child Health population.

7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.

8. Health Education: Strengthen health education in the public schools, including developing strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing system collaboration efforts that focus on defined outcomes for the MCH population. Start building the infrastructure within MCH programs to sustain efforts over time and work to include all MCH partners when planning and targeting efforts.

10. Overweight and obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children. //2006//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				100	100
Annual Indicator	98.2	99.3	97.3	95.0	100.0
Numerator	19937	20537	20404	19	16
Denominator	20302	20686	20965	20	16
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2003

In 2003 one child had a mild form of a condition and needed no treatment and one child the date of treatment initiation is unknown.

a. Last Year's Accomplishments

The newborn screening brochure was revised, reprinted and began being distributed through the Oregon Public Health Laboratory (OPHL), and Idaho's manual for practitioners was completed and placed on the internet. In mid-May, the FY04 contract with the Oregon Public Health Laboratory was amended and finalized to include testing for CAH and hemoglobinopathies. Through a grant at Oregon Health and Science University (OHSU), the program has been provided a part-time person to undertake staff education at birthing facilities across the state before she begins work on a long term follow up project this fall. The transit time of blood specimens from Idaho to the OPHL has been dangerously poor from several facilities, and this temporary staff person is making contact with those institutions to offer information, technical assistance and education.

In April, an OHSU metabolic specialist was brought to Idaho by the program to present information on newborn screening and the technology of tandem mass spectrometry at a dinner meeting with pediatricians in Idaho Falls and grand rounds at the Eastern Idaho Regional Medical Center. The following week, a nurse educator from OHSU made the same trip to present to nurses, nurse managers and early intervention staff in eastern Idaho.

State staff are members of a March of Dimes committee that is examining newborn screening and genetics issues in Idaho, and the program funded a visit and presentation to the committee by the OHSU nurse educator mentioned above and an OHSU RD who specializes in metabolic conditions. The state program is sponsoring a conference call involving staff from Idaho's largest birthing facility with OHSU and OPHL staff in July to address collection and mailing issues within that facility's two Treasure Valley campuses.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide education/technical assistance to birthing facilities and midwives in all regions of the state.		X	X	X
2. Improve cross-state services in newborn screening and genetics.		X	X	X
3. Utilize OHSU physician and nursing staff to provide in-service and grand rounds education to providers in regions I and II.		X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Idaho contracts with the Oregon Public Health Laboratory for screening and consultative services, and the most troublesome statistic concerning Idaho's screening program was the error rate of specimens submitted that took more than five days to reach the laboratory. It was the program's highest priority this year to reduce that error rate. The Idaho program manager and a nurse educator from Oregon Health and Science University (OHSU) attended the 10th annual nurse manager's summit meeting last fall and made a newborn screening presentation to the more than 30 nurse managers in attendance from medical facilities around the state. Tandem mass spectrometry technology was explained, along with the importance of the timely mailing of test kits to the Oregon laboratory. This followed visits by newborn screening staff to 33 birthing facilities in all parts of the state, during which each facility's practice profile was discussed and copies of the Idaho Practitioner's Manual were provided. Instructional videotapes featuring proper specimen collection were purchased and provided free-of-charge to the twenty largest facilities and the state's largest medical center's lending library. The transit error rate for Idaho has been reduced from a high of 41% in January of 2004 to 6% in March of 2005.

c. Plan for the Coming Year

Provider education will remain a priority this coming year. Educational/informational presentations by Oregon Health and Science University staff will be scheduled in southwest, central and northern regions of the state. Idaho will continue to investigate the possibility of adding Cystic Fibrosis screening to its battery of tests.

The program will also participate in two grants through OHSU, the first a regional cooperative grant to improve cross-state services in newborn screening and genetics, the second involving the long-term follow up of children with specific metabolic diseases.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				60	60
Annual Indicator			57.2	57.2	57.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The state staff of the Children's Special Health Program (CSHP), which consists of two professionals and an administrative assistant, also has administrative responsibility for Idaho's newborn metabolic screening and genetics programs. In addition to ongoing work in those other two very busy programs, staff was focused last year and this year almost exclusively on transitioning CSHP from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. Beginning October 1, 2004, CSHP ceased contracting with regional health departments and some 50 physician providers who organized and staffed an average of 200 annual clinics across the state, no longer enrolled public and

privately insured children in the program, and stopped assisting with the payment of deductibles and co-pays for insured families. These huge program changes have and continue to result in significant anger and confusion from families and providers. Media attention and the resulting interest on the part of state legislators extended the time commitment necessary for staff to deal with the transition.

The effort to privatize or hand off clinics to regional health departments after CSHP financial support ceased was largely successful, and the only direct services with which the program remains involved are the sponsorship of Cystic Fibrosis and PKU clinics and the care coordination and treatment of children without private or public insurance. This most vulnerable pediatric population receives statewide care coordination through a contract with the Children's Specialty Center at St. Luke's Regional Medical Center in Boise from a nurse who has served for four years as a CSHP coordinator. Bi-annual regional PKU clinics continue to be provided, in addition to monthly Cystic Fibrosis clinics in Boise.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Medicaid Healthy Connections policy staff to simplify existing program requirements for special needs families.	X	X		X
2. Utilize Family Voices grant to provide systems education to parent leaders.		X		X
3. Assist parent leaders in establishing a statewide support and education network for special needs families.		X		X
4. Continue to establish partnerships with state advocacy organizations and programs to impact services and support at the community level.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

c. Plan for the Coming Year

The SLAITS survey indicated that 58.5% of families in Idaho partnered in decision making at all levels and were satisfied with the services they receive. A May, 2002 statewide family survey, conducted as part of developmental pediatrician Dr. Nancy Mann's CATCH grant, indicated that 84.5% of families surveyed participated in decision making for their child's care and that 60% were satisfied with services received. It is important to note that families surveyed were, at the time, actively receiving care coordination services from CSHP.

Focus group discussions for Idaho's five year needs assessment supported MCHB Chartbook data that indicated a higher percentage of families with Medicaid reported problems obtaining specialty care for their children. Healthy Connections, Idaho's Medicaid managed care program, adds a step in obtaining care that requires parents to visit their primary care provider to obtain a referral to a specialist. This extra step is often burdensome to families and CSHP will work with Medicaid policy staff this coming year to examine the utility of such a requirement for the families of medically complex youngsters. Medical home education efforts aimed at physicians and described in Measure 03 should also impact this situation in positive ways.

CSHP will continue to work to better educate families about existing systems of care, with the goal of empowering parents to better understand and navigate these systems. The program is a partner in a Family Voices regional grant through the Champions for Progress Center to identify and train parent leaders from across Idaho to begin the process of establishing a statewide network of parent meetings, workshops and mentors for families with special needs children. The regional conference is set for October of this year in Oregon and CSHP will provide financial support for travel and childcare to the five families selected to participate in the training.

An effort to strengthen existing relationships with Idaho advocacy organizations will also be undertaken this year, with the goal of making it clear, through policy and action, to all relevant constituencies that CSHP values working in partnership with families, providers and other agencies/programs. Program staff will begin to work with community professionals and families to support a comprehensive understanding and appropriate use of Idaho's medical and social service systems. State staff will devote attention to facilitating, encouraging and providing families with a variety of opportunities to develop competencies and confidence in working with issues, agencies, and legislators on behalf of their children with special needs.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				50	52
Annual Indicator			49.1	49.1	49.1
Numerator					

Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52	52	52	52	52

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The state staff of the Children's Special Health Program (CSHP), which consists of two professionals and an administrative assistant, also has administrative responsibility for Idaho's newborn metabolic screening and genetics programs. In addition to ongoing work in those other two very busy programs, staff was focused last year and this year almost exclusively on transitioning CSHP from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. Beginning October 1, 2004, CSHP ceased contracting with regional health departments and some 50 physician providers who organized and staffed an average of 200 annual clinics across the state, no longer enrolled public and privately insured children in the program, and stopped assisting with the payment of deductibles and co-pays for insured families. These huge program changes have and continue to result in significant anger and confusion from families and providers. Media attention and the resulting interest on the part of state legislators extended the time commitment necessary for staff to deal with the transition.

The effort to privatize or hand off clinics to regional health departments after CSHP financial support ceased was largely successful, and the only direct services with which the program remains involved are the sponsorship of Cystic Fibrosis and PKU clinics and the care coordination and treatment of children without private or public insurance. This most vulnerable pediatric population receives
statewide care coordination through a contract with the Children's Specialty Center at St. Luke's Regional Medical Center in Boise from a nurse who has served for four years as a CSHP coordinator. Bi-annual regional PKU clinics continue to be provided, in addition to monthly Cystic Fibrosis clinics in Boise.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Pursue existing linkages with state AAP and AAFP chapters to address the medical home concept through their organizations.		**X**		**X**
2. Utilize medical home training materials developed through an AAP CATCH grant to educate Family Practice physicians.		**X**		**X**

3. Utilize the AAP Mentorship Network to provide technical assistance, training and distribution of medical home materials to physician providers.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

c. Plan for the Coming Year

The SLAITS survey indicated that only 49.1% of the respondents felt that their child was receiving coordinated, ongoing, comprehensive care within a medical home. The medical home concept is still largely unknown or misunderstood in Idaho by providers and families, and significant education needs to take place with both of those groups.

A survey in conjunction with this year's needs assessment of just over 100 families with children being served by CSHP at the time of the survey indicated that 85% of the respondents felt it was very important to have someone who can coordinate communication between physicians, hospitals and therapists. Data supports that families are explicit about the importance of this area, and given the shortcomings of the medical community in addressing that importance, it is clear that system-wide efforts are needed to strengthen communication and coordination.

Linkages are in place with the directors of Idaho's AAP and AAFP chapters, and they have both indicated an interest in and willingness to participate in new educational efforts to address the medical home concept through their organizations. The AAP state director will attempt to get medical home education placed on the chapter's priority list of activities for this next year, and is working with incoming officers to move in that direction. Dr. Nancy Mann, a developmental pediatrician at Idaho State University, developed a medical home training for family practice physicians as part of an AAP CATCH grant, and, as family practice doctors outnumber pediatricians four to one in Idaho, this will be an important constituency to include in education efforts. As part of CSHP's attempt to move the program down the MCH pyramid toward more infrastructure-building activity, the tools developed by Dr. Mann will be reviewed to determine which would be most appropriate for inclusion with statewide provider information and education activities.

It is also hoped that the AAP Mentorship Network can be utilized to provide additional technical assistance, training and distribution of medical home materials to providers. Attempts to identify, recruit and train individual in-state providers to undertake one-on-one communication with their private practice colleagues will accompany this effort.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					60
Annual Indicator			53.3	53.3	53.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The state staff of the Children's Special Health Program (CSHP), which consists of two professionals and an administrative assistant, also has administrative responsibility for Idaho's newborn metabolic screening and genetics programs. In addition to ongoing work in those other two very busy programs, staff was focused last year and this year almost exclusively on transitioning CSHP from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. Beginning October 1, 2004, CSHP ceased contracting with regional health departments and some 50 physician providers who organized and staffed an average of 200 annual clinics across the state, no longer enrolled public and privately insured children in the program, and stopped assisting with the payment of

deductibles and co-pays for insured families. These huge program changes have and continue to result in significant anger and confusion from families and providers. Media attention and the resulting interest on the part of state legislators extended the time commitment necessary for staff to deal with the transition.

The effort to privatize or hand off clinics to regional health departments after CSHP financial support ceased was largely successful, and the only direct services with which the program remains involved are the sponsorship of Cystic Fibrosis and PKU clinics and the care coordination and treatment of children without private or public insurance. This most vulnerable pediatric population receives statewide care coordination through a contract with the Children's Specialty Center at St. Luke's Regional Medical Center in Boise from a nurse who has served for four years as a CSHP coordinator. Bi-annual regional PKU clinics continue to be provided, in addition to monthly Cystic Fibrosis clinics in Boise.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Utilize needs assessment and "summit meeting" data and information to recruit representatives from a variety of organizations to address this issue.		X		X
2. Work with Medicaid staff to clarify and standardize statewide application procedures for the Katie Beckett program.		X		X
3. Re-initiate exploration of adapting Wisconsin's Health Insurance Guidebook for Idaho users.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

c. Plan for the Coming Year

National SLAITS data revealed that 53.3% of the families surveyed in Idaho indicated that they had adequate health insurance for their special needs child or children. When insured children were enrolled in CSHP prior to October, 2004, the most common problem for them was the exclusion of certain necessary medical equipment or procedures or simply being "under insured" relative to the intensity of care needed.

There remain significant differences between public and private insurance coverage. Medicaid expenditures in Idaho, as in many states, are under regular and increasingly intense scrutiny by legislators. This year, as the possibility of exploring a Medicaid carve out for special needs youngsters was suggested by CSHP, Idaho legislators involved in those discussions did not hesitate to explain that legislative leadership had served notice that no expansion to the Medicaid budget would be allowed. That information stalled further discussion of the matter. In an attempt to look at other possible options, a special needs "summit" meeting has been scheduled in June, and a wide variety of invitees to that meeting, who include representatives from the "Blues," providers, families and advocacy organizations, will begin that process.

The survey of Idaho families as part of this year's needs assessment indicated that while there are numerous positive aspects of Medicaid coverage for special needs children, there are also numerous challenges that families face in accessing and using Medicaid. One of the most significant of these involves the difficulty families have in finding out about, applying for, and maintaining benefits in the Katie Beckett program. Parents reported that many Medicaid eligibility workers were unaware of the rules for Katie Beckett and were unable to assist them with applying. This has been an ongoing problem in Idaho, and it is hoped that CSHP staff this year will be able to initiate meetings with Medicaid policy staff to explain the issue and begin the process of exploring possible remedies.

CSHP also will work to be a catalyst pertaining to insurance issues through partnering with families and advocacy groups to explore alternative sources of medical insurance for special needs children. One important resource mentioned in last year's narrative involves the Health Insurance Guidebook developed in Wisconsin by ABC for Health. Discussion with the group was initiated last year to explore the possibility of developing an Idaho-specific version of the Guidebook, but transition issues prevented continuing the dialogue. It is a goal this coming year to re-initiate that conversation.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				77	80
Annual Indicator			75.2	75.2	75.2

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The state staff of the Children's Special Health Program (CSHP), which consists of two professionals and an administrative assistant, also has administrative responsibility for Idaho's newborn metabolic screening and genetics programs. In addition to ongoing work in those other two very busy programs, staff was focused last year and this year almost exclusively on transitioning CSHP from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. Beginning October 1, 2004, CSHP ceased contracting with regional health departments and some 50 physician providers who organized and staffed an average of 200 annual clinics across the state, no longer enrolled public and privately insured children in the program, and stopped assisting with the payment of deductibles and co-pays for insured families. These huge program changes have and continue to result in significant anger and confusion from families and providers. Media attention and the resulting interest on the part of state legislators extended the time commitment necessary for staff to deal with the transition.

The effort to privatize or hand off clinics to regional health departments after CSHP financial support ceased was largely successful, and the only direct services with which the program remains involved are the sponsorship of Cystic Fibrosis and PKU clinics and the care coordination and treatment of children without private or public insurance. This most vulnerable pediatric population receives statewide care coordination through a contract with the Children's Specialty Center at St. Luke's Regional Medical Center in Boise from a nurse who has served for four years as a CSHP coordinator. Bi-annual regional PKU clinics continue to be provided, in addition to monthly Cystic Fibrosis clinics in Boise.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Utilize existing collaborative relationships with Family Voices and Idaho Parents Unlimited to include surveys and information about this performance measure.		**X**		**X**

2. Work with Medicaid policy staff to provide training and information to contracted care coordinators about the complexities of special needs children and their families.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

c. Plan for the Coming Year

SLAITS data indicated that 75.2% of Idaho families felt that special needs service systems were organized so they could use them easily. At the time of the SLAITS survey, most families contacted were enrolled in CSHP, and the program, through its health department care coordination contractors, helped families navigate systems of care across the state. That component remains in place for the uninsured children now enrolled in the program, but families with insurance face new challenges without CSHP involvement.

Focus groups with CSHCN families held as part of this year's needs assessment revealed that many parents with insurance who were no longer enrolled in CSHP reported a significant lack of coordinated services. Parents reported that it was difficult to find updated information about programs, services and eligibility for other resources. Even during the focus groups, families were updating each other about changes in programs and suggesting ways to find information and services.

The needs assessment provided additional confirmation that Idaho's Medicaid care coordination system leaves much to be desired when it comes to assisting children with complex medical issues. Focus group participants expressed a clear need for care coordination services, but reported very mixed experiences with individual Medicaid care coordinators. Parents were confused about just what services these care coordinators were supposed to provide, and some reported that they did not find coordinator's advice useful, did not find them respectful, so they stopped using their services. Parents who participated in focus groups were also worried that while medical care was still available to their children, support services were

more likely to be limited and the lack of experience of care coordinators with complex medical issues would be problematic. Such anecdotal information only serves to verify the need for CSHP to provide technical assistance, training and education to contracted Medicaid care coordinators, and that goal, as previously referred to in performance measure 04, will be high on CSHP's priority list this coming year.

As reported in last year's narrative, discussion has already occurred with the leadership of Family Voices and Idaho Parents Unlimited (IPUL) to include information about this issue with the other initiatives CSHP hopes to undertake with them this coming year. Family Voices and IPUL have agreed to assist CSHP with identifying community individuals and groups that are already involved with families in various ways, and those local contacts will strengthen efforts to address this issue. CSHP will continue to build upon an existing and positive relationship with Idaho's early intervention program, and will provide educational and information materials for that program's newsletters and conferences.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				6	6
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance

measure.

a. Last Year's Accomplishments

The state staff of the Children's Special Health Program (CSHP), which consists of two professionals and an administrative assistant, also has administrative responsibility for Idaho's newborn metabolic screening and genetics programs. In addition to ongoing work in those other two very busy programs, staff was focused last year and this year almost exclusively on transitioning CSHP from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. Beginning October 1, 2004, CSHP ceased contracting with regional health departments and some 50 physician providers who organized and staffed an average of 200 annual clinics across the state, no longer enrolled public and privately insured children in the program, and stopped assisting with the payment of deductibles and co-pays for insured families. These huge program changes have and continue to result in significant anger and confusion from families and providers. Media attention and the resulting interest on the part of state legislators extended the time commitment necessary for staff to deal with the transition.

The effort to privatize or hand off clinics to regional health departments after CSHP financial support ceased was largely successful, and the only direct services with which the program remains involved are the sponsorship of Cystic Fibrosis and PKU clinics and the care coordination and treatment of children without private or public insurance. This most vulnerable pediatric population receives statewide care coordination through a contract with the Children's Specialty Center at St. Luke's Regional Medical Center in Boise from a nurse who has served for four years as a CSHP coordinator. Bi-annual regional PKU clinics continue to be provided, in addition to monthly Cystic Fibrosis clinics in Boise.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Utilize Health and Ready to Work information and assistance.		X		X
2. Explore linkages with youth-oriented agencies and programs to include special needs children in existing activities.		X		X
3. Renew efforts to work through Idaho Division of Vocational Rehabilitation to address the transition issues of special needs youngsters.		X		X
4. Utilize Champions for Progress Idaho team members to approach condition-specific agencies and programs to identify and address transition issues.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing,

remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

c. Plan for the Coming Year

Like many other states, Idaho has struggled to provide the services necessary to help special needs children make the transition to adult life. A family survey conducted as part of this year's needs assessment revealed that 49% of the parents surveyed needed much more information about services to assist with preparing their children for adulthood. National Bureau of Special Education data suggests that school systems attempt to help with this issue, with almost 75% of high school graduates reporting that their high schools helped connect them with employment and college counseling, or agencies such as vocational rehabilitation. But, outside the educational system, and especially in Idaho, very little in the way of resources exists to assist with this performance measure.

CSHP will once again attempt to work productively with Idaho's Division of Vocational Rehabilitation to better address these issues. While an informal agreement with IDVR was reached several years ago, ongoing contact with the agency ceased with personnel changes and time, so it will be necessary to renew that effort.

As mentioned in last year's narrative, in addition to planned collaborative relationships with groups across the state that are also interested in special needs transition issues, the Idaho team that attended the 2004 Champions for Progress meeting in Utah had the opportunity to meet with staff from Healthy and Ready to Work, and will plan to utilize information and assistance available from that group. Resources from HRTW's website will provide assistance in terms of data and other tools that can be used in planning strategies for this performance measure.

As CSHP staff time allows, activities to be pursued include working with youth-oriented agencies and organizations to encourage ways to connect disabled young people to each other and adult mentors, working with state Independent and Developmental Disabilities councils to explore collaborative efforts, identifying and working with state condition-specific agencies and programs, finding ways to connect CSHP with youth leadership organizations such as 4-H, Special Olympics, and community parks and recreation programs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	72	74	76	77	80
Annual Indicator	70	70.2	69.4	79	80.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	82	83	84	85

Notes - 2002

The percentage comes for the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2003

The percentage comes for the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2004

The percentage comes for the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

a. Last Year's Accomplishments

The Immunization Program provided free vaccines to district health departments and private providers for the provision of immunizations to children, including Hepatitis A. This activity combined with those described in the annual plan, did have a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). The most recent National Immunization Program Survey revealed that Idaho's immunization rate (4:3:1) is 84.0%

A major focus of the Immunization Program this past year has been increased provider education. These are regional conferences held throughout the state, focused on increasing immunization awareness, administration and storage of immunizations, as well as how to talk to parents about the importance of immunizations. The Immunization program continues to grow annually making education even more imperative. Site visits were conducted at nearly all VFC provider offices throughout the state. These visits are focused on working directly with the clinic staff to make sure they are following the 17 Standards of Immunization Practices. The program provides technical assistance when necessary. . The Program also continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services. This includes screening every WIC child's immunization record to verify they are up-to-date.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free vaccine to all Vaccine for Children (VFC) providers.			X	

2. Perform annual site visits to all VFC providers and conduct provider education.			X	
3. Provide parent, school and daycare education.			X	
4. Maintain an immunization registry.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program will continue to provide vaccines to all public and private providers in the state. The program will work directly with these providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.

The Immunization Program also worked with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program worked closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program focus areas included: parent education; provider education; reminder/recall; review and assessment of WIC clients

Local events will be taking place over the next several weeks as part of the back to school get kids up to date effort. Quality assurance reviews have continued. Planning for QAR visits to determine focus areas for the site reviews for coming year is underway. August is national immunization month.

Finally, the Idaho school and daycare laws to require a 2nd dose of MMR and a 5th dose of DTaP were approved. This process will required the approval by the Board of Health and Welfare and the Idaho legislature prior to full implementation.

c. Plan for the Coming Year

The Immunization Program will continue to work hard to provide vaccines to all public and private providers in the state free of charge for all children 0-18 years of age. The program will work directly with these providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.

The Immunization Program will continue to work with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider. Finally, the program will develop a plan for working more directly with parents empowering them to take charge of their child's immunization status. In addition, the program will begin working with Medicaid to identify barriers to immunizations within this distinct population. The development of a Medicaid/Immunization linkage is currently being discussed.

During FY 2006, the Immunization Program will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will maintain a registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series.

Additionally, during FY 2006, the Immunization Program will continue a population-based implementation program to increase hepatitis A immunizations and will include implementation of Varicella surveillance and population based immunizations by (1) targeting children according to ACIP recommendations and (2) providing the vaccine at no cost as part of its general statewide distribution.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program will continue to conduct or contract for activities in four major areas: (1) parent education; (2) provider education; (3) reminder/recall; and (4) review and assessment of WIC clients.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	24.9	17	16	15
Annual Indicator	21.0	19.0	18.4	17.5	
Numerator	669	604	582	545	
Denominator	31901	31718	31561	31176	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	13	12	11	11

Notes - 2002

Data not available for 2002, but will be available in November 2003.

Notes - 2004

Data from Idaho birth certificate data available due to revisions in birth certificate for 2004. Data will be available September 2005.

a. Last Year's Accomplishments

8,239 teens , less than 20 years of age, received physical assessment, education and counseling through the Reproductive Health Program during CY 2004. The Idaho teen pregnancy rate which had continued to decline at 49.0 in 2000, 48.1 in CY 2001, 45.3 in CY

2002, demonstrated only a slight increase in CY 2003 at 45.8 for 15-19 year olds.

Providers in the clinics emphasized adolescent education which focuses on abstinence, parental involvement, as well and contraception and STD prevention. Monitoring of the quality of clinic services includes documentation audits as well as clinic observation by State agency staff.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to teens through the public health districts.	X		X	
2. Maintain relationship with Title X compliant community health centers become Title X compliant so they can access contraceptives through Idaho's multistate purchasing agreement. Expand the number of centers participating.	X			X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Reproductive Health Program continues to emphasis outreach activities to teens. Health districts continue to collaborate with the Adolescent Pregnancy Prevention Program to encourage delaying sexual activity and abstinence in the teen population.

Central District Health actively promotes healthy choices for the teen community with the presence of an adolescent health educator. The full time educator is active in the community providing outreach and guidance in such locations as the Boys and Girl's club, juvenile detention centers, teen substance abuse support groups, youth coalitions, and health fairs. The focus of education is self esteem building as the foundation of making healthy decisions about life and sexuality.

In CY 2005, District I was involved in a coalition effort to plan a ""Girl's Summit" for the North Idaho and Eastern Washington region. Objectives for the summit were to provide support and education for girls aged 12-15 in order to elevate self esteem and promote healthy lifestyle choices in adolescents.

All health districts provide extended clinic hours in the evening in order to accommodate teen clients. Confidential family planning services are provided for all teens in all Idaho Reproductive Health Program clinics.

Public health providers in the Family Planning clinics continue to contract with local schools to provide education services with specific content varying from county to county.

c. Plan for the Coming Year

The Reproductive Health Program will continue to promote the care of adolescent clients by increasing visibility of services in the community. Health educators and public health staff will identify and address the changing health education needs of adolescents with a goal to provide family planning services and educational outreach to a target of more than 10,000 teens. Services include medical care as well as individual age appropriate counseling and education in order to continue to decrease the teen pregnancy rate.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	51	50	50.5	60	62
Annual Indicator	47.8	53.6	59.7	49.9	50.1
Numerator	9236	10361	11430	9426	370
Denominator	19323	19332	19147	18890	739
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64	66	68	70	72

Notes - 2004

Data is from a survey of every third grade class in Idaho Falls school district # 91. State representative data will be available in 2005 from the Idaho State Smile Survey.

a. Last Year's Accomplishments

During 2004, the MCH Oral Health Program again contracted with each of the seven district health departments to conduct population-based preventive oral health programs. Through the district contracts, 861 children received free dental sealants and 17,991 received information regarding sealants and preventive dental care through classroom education. The sealant projects are targeted to students in grades 2 and 3 at schools with 50% or more of students on the free and reduced school lunch program. Funding was provided to three health districts to purchase or upgrade dental equipment to expand their sealant efforts. In addition, two health districts worked with their dental communities to coordinate and facilitate Give Kids A Smile Day activities, which served 1,840 children and 350 adults. The Regence Blue Shield Caring Foundation secured funding that enabled one health district to offer free dental sealants through the Boys and Girls Club in addition to the schools.

Statewide data on dental sealant prevalence is not available for 2004. However, a 2004 survey of Idaho Falls School District # 91 third grade students found that 50% had one or more sealants in permanent molars. Among students with sealants, 79% were caries-free in their

permanent teeth, compared to only 64% of those without sealants.

State and district representative data to evaluate the MCH dental sealant performance measure will be collected via the 2005 Idaho State Smile Survey of third grade students. Sample schools were identified in April 2004 and funding provided to the Health Districts to confirm schools' participation and to purchase supplies. Examiner standardization training was held in August 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V support for district oral health programs will be maintained at the current level.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH funding to conduct dental sealant projects is continuing during 2005. Resources identified through other community partners, most notably Regence Blue Shield Caring Foundation and the Idaho Dental Hygienists' Association, have enabled expansion of the sealant project via two free sealant days held in Health District 5. Due to the demands of conducting the 2005 Idaho State Smile Survey and limited dental hygienist staff time, Health District 2 was unable to initiate a sealant project in 2005 as planned. However, they developed protocols and a manual and are planning to start their sealant project in Fall 2005. Idaho State Smile Survey data collected during the 2005 school year will be entered into a database by the end of September 2005.

c. Plan for the Coming Year

During 2006, Title V support for district oral health programs, including the dental sealant projects, will be maintained at the current level. Data from the 2005 Idaho Smile Survey will be analyzed and a report card developed for distribution. The possibility of partnering with Kids Count to issue a position paper and convene a policy forum during February 2006 in conjunction with release of the oral health report card has been discussed.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.3	7.1	5	5	4.5
Annual Indicator	6.4	5.6	5.6	6.8	
Numerator	18	17	17	21	
Denominator	283307	305087	305614	307803	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4	4	4

Notes - 2002

Data not available for 2002, but will be available by November 2003.

Notes - 2004

Idaho mortality database not finalized because not all out of state deaths certificates have been received. Data will be available September 2005.

a. Last Year's Accomplishments

The Injury Prevention Program contracted with health districts statewide to provide public risk reduction for motor vehicle related injuries.

In addition, the program worked with the Idaho Transportation Department and health districts to coordinate statewide efforts to promote motor vehicle, pedestrian, and bicycle safety statewide.

The Injury Prevention Program also facilitated injury prevention coalitions throughout Idaho comprised of partners from law enforcement, education, health care organizations, insurance companies, private industry, and the media.

MCH funding allowed the purchase of 200 child car safety seats that were distributed to low income parents and caregivers throughout Idaho.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The Injury Prevention Program contracted with health districts statewide to provide public risk reduction for child motor vehicle injury prevention programs. A focus area of the contracts includes a train the trainer program in which the public health districts trained community partners to teach parents/care givers to correctly install child care safety seats.

The Injury Prevention Program and health districts statewide are working to transition the distribution of child car safety seats, and the training necessary to install those seats correctly, to state and local partners. MCH funding allowed for the purchase of 326 child car safety seats and booster seats that were distributed to low income parents and caregivers throughout Idaho.

c. Plan for the Coming Year

The Injury Prevention Program will continue to contract with health districts statewide to provide public risk reduction for children's motor vehicle related injuries. The program will contract with health districts to continue train the trainer programs in which community partners are trained to teach parents/care givers to correctly install child care safety seats. Child car safety seats will be distributed to low income families.

During the year the program will work with health districts to transition the program to community partners by FY07.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	72.5	72.6	72.7	75	76
Annual Indicator	73.4	74.6	74.3	73.6	73.1
Numerator	13183	13483	13666	13961	14406
Denominator	17955	18076	18398	18977	19703
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	78	79	80	81

a. Last Year's Accomplishments

1) The Idaho WIC Program is making efforts to promote and support breastfeeding as the normal way to feed infants. With the American Academy of Pediatrics New Policy on Breastfeeding (Journal of the American Academy of Pediatrics February 7, 2005) which recommends exclusive breastfeeding for 6 months and breastfeeding with addition of appropriate solids up to 2 years and beyond, the WIC Program is striving to promote these. During FY04-05, Idaho continued to provide breastfeeding resource and referral information to health care providers, childcare centers, WIC Programs, and work sites around the state. This included a link to the Department of Health and Welfare website where these materials could be found as well as upcoming breastfeeding trainings in and around the state.

2) The Idaho WIC Breastfeeding Promotion and Support Work Group completed the electric breast pump project. Every health district around the state now offers electric breast pumps to WIC mother's who are returning to work or school using the guidelines set by this group. It is hoped that this will assist in increasing the breastfeeding duration rates in Idaho.

3) The Second Annual Idaho Breastfeeding Conference for Health care Professionals was held in June 2004. Breastfeeding Coalition members, health care providers, and Local Agency WIC staff from around the state attended. A planning committee that included people from around the state came together to develop an agenda that was specific to the needs of breastfeeding support in Idaho. Nationally renowned speakers were brought in and time was given during the conference to collaborate on breastfeeding promotion and support efforts from around the state.

The CY2004 Idaho Breastfeeding Study data shows that 73.1% of Idaho's infants were exclusively breastfed at or near hospital discharge, a decrease of 0.5% from the CY2003 rate of 73.6%. Numbers of total breastfed (exclusive and combination feeding) have increased from CY03 rate of 87.4% to CY04 rate of 87.8%, an increase of 0.4%.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide at least one statewide breastfeeding training/conference.				X
2. Establish an Idaho Breastfeeding Promotion and Support website.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) The Breastfeeding resource and referral information Best Start Catalogue can still be found on the IDHW website as well as information about upcoming breastfeeding trainings in and around the state and current breastfeeding information.

2) The Breastfeeding Promotion and Support Group is in the final phases of a plan for postpartum breastfeeding education to be provided in the WIC program with emphasis on helping mother's through the first few months which is when most mother's stop breastfeeding. The plan includes a training guide for WIC staff.

3) The Breastfeeding Promotion and Support Group collaborated to revise breastfeeding handouts distributed to health care providers and childcare centers using the WIC Image Project in order to make our product identifiable.

4) Idaho WIC Program Best Practice Grants were revised and WIC Agencies were encouraged to achieve higher standards in breastfeeding education and credentials.

5) The Third Annual Idaho Breastfeeding Conference for Health care Professionals will be held August 2005. A planning committee from around the state has met to determine the appropriate agenda and speakers that will inspire and facilitate breastfeeding promotion and support efforts. A networking lunch with assigned topics will provide people from around the state with ideas and assistance they may need in order to better promote breastfeeding in their area. IDHW has submitted a request for Governor Kempthorne to declare August World Breastfeeding Month by signing a proclamation. The proclamation will be presented at this conference.

6) Elaine Long, PhD, RD, LD (BSU Professor) will present data from the Idaho WIC computer system on breastfeeding duration, demographics, and reasons women stop breastfeeding at the WIC day of the Third Annual Idaho Breastfeeding Conference for Health care Professionals.

7) The State Office continued to provide guidance and support for World Breastfeeding Month activities throughout WIC agencies and Local Breastfeeding Coalitions throughout Idaho.

c. Plan for the Coming Year

In FY06, the State WIC Office will hold a biennial WIC training. One day of the training will be set aside to train staff on current breastfeeding recommendations and ways to implement these in WIC clinics.

In FY06, the State Breastfeeding Promotion and Support Group will prioritize their goals and start a new project. It will also use the research presented by Elaine Long, PhD, RD, LD on Idaho WIC Breastfeeding data to guide its decisions.

In FY06, the State Office will begin to support efforts of Local Breastfeeding Coalitions to hold trainings that attract health care professionals and community members who work with populations that would benefit from breastfeeding education to meet specific needs for their area.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	64	80	82.5	100	100
Annual Indicator	77.2	91.4	96.8	97.4	97.7
Numerator	14646	16798	18275	19532	20070
Denominator	18964	18383	18886	20060	20540
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During Calendar Year (CY) 2004, 98% of babies born in Idaho hospitals were screened for hearing at birth. The Council for the Deaf and Hard of Hearing is continuing to receive funds from a federal grant for the Early Hearing Detection and Intervention (EHDI) program in Idaho along with the Idaho Newborn Hearing Screening Consortium. The program works with the EHDI program to train hospital staff and audiologists in Idaho to assure that babies who do not pass the two-stage screening are referred promptly for and receive diagnostic testing.

During CY 2004, 22 infants were identified with permanent sensorineural hearing loss. For CY 2004, there were also 11 infants identified with a conductive loss and 1 infant with a mixed hearing loss (permanent sensorineural loss and conductive hearing loss). All infants referred for a diagnostic evaluation received the evaluation or are receiving follow up services from their physician. Many have received hearing aids and are enrolled in early intervention programs.

The Idaho Newborn Hearing Screening Consortium, in collaboration with and the support of the Idaho Bureau of Clinical and Preventive Services, is developing a sustainable system for early detection, intervention and follow-up of children born with diagnosed hearing loss.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V support for district oral health programs will be maintained at the current level.			**X**	**X**
2. Match or exceed the national benchmarks set by JCIH.			**X**	
3. Increase family to family support and access to information to assist families.		**X**		
4. Expand newborn hearing screening to other community-based sites, e.g. district health departments.			**X**	**X**
5. Increase and improve the participation of physicians in EHDI and in the provision of a medical home.				**X**
6.				
7.				
8.				

9.				
10.				

b. Current Activities

In 2004 a Memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing was renewed and the council provided:

(1) Monitoring and data collection;
(2) Hospital support, recruitment, and community education;
(3) Training; and
(4) Consortium support in an effort to increase follow up to those families where the infant has not passed the newborn hearing screening.

c. Plan for the Coming Year

Continuing in FY 2006, the Title V agency will renew the memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing, to provide services related to the Idaho Newborn Hearing Screening. The Consortium's Early Hearing Detection and Intervention project will be in its 6th year of funding during FY 2006. During year 6 Early Hearing Detection and Intervention will be supported by continued federal funding or State General Fund resources, integrated with the service delivery program for children age 0 to 3, meet or exceed JCIH benchmarks on a statewide basis, and have 70% of hospitals achieving at the JCIH benchmark levels or above on 3 of the four performance measures.

Specific activities for the coming year include:

Monitor hospital performance related to coverage, referral rate, percentage of children receiving diagnostic evaluations, and early intervention services, and provide assistance as needed;

Provide culturally competent information about newborn hearing screening and the importance of early intervention to Hispanic families.

Collaborate with nurse midwives and other professionals to address the need for newborn hearing screening for infants born at home.

Increase and improve the participation of physicians in EHDI and in the provision of a medical home for infants with hearing loss.

Seek resources from private and public sources to support diagnostic services and necessary interventions, including fair payment for treatment and hearing aids.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	12.3	12.2	12.1	12	12

Objective					
Annual Indicator	13	13	13	13	13
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	12	12	12	12

Notes - 2002

Data is from the Current Population Survey by the US Census Bureau for the years 2000-2001.

Notes - 2003

Data is from the Current Population Survey by the US Census Bureau for the years 2000-2001 Could not find numerator and denominator.

Notes - 2004

2004 CPS data not available.

a. Last Year's Accomplishments

The Title V agency worked with the Division of Medicaid on outreach activities related to the implementation of the Children's Health Insurance Program (CHIP). Those efforts lead to expansion of benefits for children under a new program called CHIPB. CHIP B provides coverage for children whose family incomes are greater than the CHIP A maximum allowable of 150% of the federal poverty level but equal or less than 185% of the FPL. Unlike Medicaid and CHIP A, the benefits are limited primarily to preventive health care services.

Medicaid offers an Access Card to address the needs of uninsured children. With the Access Card, the state subsidizes the parent's purchase of private insurance up to $100/child/month, with a maximum of $300/family/ month. Parents may choose to buy insurance through an employer or a private insurance company. Parents must pay the balance of the premium, deductibles, and co-pays as applicable. The covered services are determined by the private insurance carrier and the family income must not exceed 185% of the federal poverty limit. Children must be under 19 years of age to be eligible for the CHIP Access Card.

The CHIP B program was set up to have an enrollment cap as established by the state legislature. The initial open enrollment period yielded little activity. In an attempt to increase participant interest, a recruitment effort was made in conjunction with the annual back to school events at the start of the school year. This increased levels of interest and participation, but not enough to reach the program's cap.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement expanded CHIP coverage.				X

2. Work toward gaining expanded Medicaid coverage for young women of reproductive age.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The lack of intense interest in the CHIP B program raises the question how many families are truly in need of health insurance that are not currently covered by Medicaid or CHIP A. The program has a continual open enrollment.

c. Plan for the Coming Year

The Title V program will continue to work with the Division of Medicaid to promote the new CHIP-B program to eligible children. The Title V Program will continue to work with Medicaid to expand eligibility for medical services for women and children. The program will continue to utilize the Idaho CareLine to identify needs, locate services for families and make referrals for services. The Title V program will utilize grant funds to provide services, through contracts with public health districts, for needed services for women and children.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	73	73.1	73.2	90	95
Annual Indicator	83.2	87.1	89.5	94.3	92.5
Numerator	88994	113555	127524	142394	150105
Denominator	106909	130313	142425	151017	162240
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95.5	96	96.5	97	97.5

Notes - 2002

Working on getting the figures for CY2001.

Notes - 2003

Data not available for 2003.

a. Last Year's Accomplishments

Promotion of the toll-free information and referral telephone service, Idaho CareLine, to the MCH, Infant Toddler and Medicaid populations (including CHIP referrals).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CareLine will continue to refer callers to Medicaid, when appropriate.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHP continues to work, through its clinic network and parent group, to increase the awareness of families about CHIP and Medicaid coverage.

Idaho CareLine continued to refer callers to Medicaid, when appropriate.

c. Plan for the Coming Year

CSHP will continue to work, through its clinic network and parent groups, to increase the awareness of families about CHIP and Medicaid coverage.

The Title V agency will continue to work with Medicaid on outreach activities related to referral to Medicaid services. It will collaborate with the district health departments and the regional offices of Health and Welfare in the coordination of health services between the two groups.

Idaho CareLine will continue to refer callers to Medicaid, when appropriate.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	1	1	1	0.8	0.7
Annual Indicator	1.1	1.0	1.0	1.0	
Numerator	220	200	201	228	
Denominator	20294	20686	20954	21780	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.6	0.5	0.4	0.3	0.3

Notes - 2002

Data not available for 2002, but will be available by November 2003.

Notes - 2004

Data from Idaho birth certificate data available due to revisions in birth certificate for 2004. Data will be available September 2005.

a. Last Year's Accomplishments

The Reproductive Health Program provided family planning services to 32,934 low income individuals in order to reduce low birth weight infants. 9,367 pregnancy tests were done by family planning providers who also provide appropriate prenatal referrals, preconception teaching, and prescriptions for vitamin supplements as indicated. In two districts, partnerships exist with the March of Dimes to provide folic acid supplements for women pregnant or of child bearing age. 1,938 women had positive pregnancy tests and were screened for various risk factors which result in low birth weight and poor pregnancy outcomes. Comprehensive screening in family planning clinics help to ensure appropriate education, counseling and referrals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Alcohol, Tobacco and other Drugs initiative.			**X**	**X**
2. Provide family planning services to reduce the rate of unintended pregnancies.			**X**	
3. Provide WIC services to pregnant women.			**X**	
4. Enhance data capabilities of PRATS.				**X**
5. Oral health project to educate obstetric providers on the importance of dental care, improve population awareness, increase referral, and establish sites to accept low income pregnant women through the dental residency programs.		**X**	**X**	**X**
6.				
7.				
8.				

9.				
10.				

b. Current Activities

The Reproductive Health Program continued to provide family planning services through contractors to reduce the rate of unintended pregnancies which has a direct link to reducing low birth weight. The Program also provides pregnancy testing and referral services to ensure early initiation of prenatal care. The program also screens all pregnant women for substance use and abuse and provides appropriate counseling, education and referrals. Because of increased violence during pregnancy and it's impact on pregnancy outcomes, the district contractors use standard screening tools for family violence and screen all pregnant women.

The state WIC office serves pregnant women who are nutritionally at risk by providing food and nutrition counseling in an effort to ensure the best possible birth outcome.

The Pregnancy Risk Assessment Tracking System (PRATS) provides data describing populations and risk factors that lead to low birth weight. The reports are disseminated among the public health districts, obstetricians, and the Idaho Perinatal Project.

A contract was established with the Idaho Perinatal Project (IPP) to begin data collection on the impact of lay mid-wives on hospitals and high risk deliveries. Because of Idaho's geography and rural communities, lay mid-wives are often used for home births or deliveries outside of a hospital setting. Overall lay-midwives deliver approximately 1.3% of all births in Idaho. Of particular concern is the increase in VBAC's (Vaginal Birth After Cesarean) that are being attended to by lay-midwives (3.5% in 2003 up from 1.1% in 1999). The risk to mother and child from these procedures and the lack of licensure/certification required in Idaho for lay-midwives, caused the IPP to begin researching the full impact this is having on high-risk deliveries and negative birth outcomes. One problem identified early was the reporting of negative birth outcomes that start with a lay-midwife and end with a transfer to the hospital for complications associated with the delivery. Hospitals had no way to report or track the births coming to them that start with a lay-midwife. The IPP developed a tracking form that is completed by the hospital when a delivery complication comes to them. This data is then submitted to the IPP for tracking purposes.

c. Plan for the Coming Year

Clinics will continue to provide pregnancy testing and referrals for all women to ensure adequate prenatal care and a decreased risk for low birth weight infants. Appropriate education and counseling, combined with quality medical services, reduces the incidence of unintended pregnancy. In CY 2005 and 2006, clinic site audits will focus on documentation of appropriate referrals for substance and alcohol abuse, and tobacco cessation as well as monitoring the quality of medical care and education.

The contract with the IPP will be continued with a goal of taking the data collection stage to developing next steps regarding hospital policy on VBAC, education of lay-midwives in a more collegial method and public awareness about the options for delivery if you are at-risk for problematic delivery. The plan for the next year will be finalized in August of 2005.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	16.8	16.7	20	19	13
Annual Indicator	18.9	21.3	13.7	13.8	
Numerator	21	24	15	15	
Denominator	110858	112936	109671	108796	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	11	10	9	9

Notes - 2002

Data not available for 2002, but will be available by November of 2003.

Notes - 2004

Idaho mortality database not finalized because not all out of state deaths certificates have been received. Data will be available September 2005.

a. Last Year's Accomplishments

Starting in April 2003, the Injury Prevention Program began working with the Idaho Department of Health and Welfare, Division of Family and Community Services, the Department of Education, and SPAN-Idaho (the Boise State University-based group) to develop a comprehensive statewide suicide prevention plan. The plan has been completed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A state-level public / private partnership (Youth Suicide Prevention Early Intervention Coalition) will be developed and functioning.				X
2. Culturally competent best practices for suicide prevention and early intervention will be developed, made available statewide, and in use in communities throughout Idaho.				X
3. Provide gatekeeper training for university residence hall staff, other student staff, and other community gatekeepers to be identified.				X
4. A TeenScreen technical assistance center will have been opened and training will have been conducted on application procedures and screening implementation.				X
5. Statewide suicide prevention referral sources will be identified and qualified resources included in the 2-1-1 Idaho CareLine database.		X		X
6. Low-cost campaign materials to increase awareness of suicide risks				

and available prevention resources will be developed and made available for community use on the TelIda website.			X	X
7. A system for providing information and statistics on youth suicide in Idaho will be developed and functioning.				X
8.				
9.				
10.				

b. Current Activities

Pending receipt of funding for a grant recently submitted for youth suicide prevention, the implementation of the state suicide plan will be implemented. This grant will be administratively housed in the Department of Health and Welfare's Division of Family and Community Services.

c. Plan for the Coming Year

Pending receipt of grant funding, an Idaho Youth Suicide Prevention and Early Intervention Program will be implemented. The purpose of the Project is to reduce suicide attempts and completions among Idaho youth aged 10-24 by implementing goals from Idaho's Suicide Prevention Plan. Most project activities result in sustainable products such as culturally competent tool boxes that will be made available on the telehealth (TelIda) website, a resource directory that will be maintained on 2-1-1 Idaho CareLine, training of community gatekeepers, TeenScreen, and the development of the Youth Suicide Prevention Early Intervention Coalition which has the potential to be subsumed into a future permanent oversight structure.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	58.5	58.6	65	66	75
Annual Indicator	64.5	59.5	65.7	72.8	
Numerator	142	119	132	142	
Denominator	220	200	201	195	
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

data will be available for 2002 in approximately November of 2003.

Notes - 2003

Data for very low birth babies born at high-risk facilities are based on Idaho resident births in Idaho. Idaho does not receive hospital name for out of state births, therefore designation of high-risk facilities for babies born out of state is not available. Numerator is based on births to Idaho residents in Idaho and denominator is based on Idaho resident births.

Notes - 2004

Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure.

a. Last Year's Accomplishments

The PRATS survey monitors utilization of neonatal intensive care services. This information is provided to groups that may influence decisions such as obstetricians closely monitoring pregnancies and ensuring transfers of their patients to facilities with neonatal intensive care units prior to delivery. The data may also influence regional medical centers to consider establishing a neonatal intensive care unit.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PRATS survey monitored utilization of neonatal intensive care services and shared the data with groups that may influence decisions such as obstetricians.

2004 - A contract was established with the Idaho Perinatal Project (IPP) to begin data collection on the impact of lay mid-wives on hospitals and high risk deliveries. Because of Idaho's geography and rural communities, lay mid-wives are often used for home births or deliveries outside of a hospital setting. Overall lay-midwives deliver approximately 1.3% of all births in Idaho. Of particular concern is the increase in VBAC's (Vaginal Birth After Cesarean) that are being attended to by lay-midwives (3.5% in 2003 up from 1.1% in 1999). The risk to mother and child from these procedures and the lack of licensure/certification required in Idaho for lay-midwives, caused the IPP to begin researching the full impact this is having on high-risk deliveries and negative birth outcomes. One problem identified early was the reporting of negative birth outcomes that start with a lay-midwife and end with a transfer to the hospital for

complications associated with the delivery. Hospitals had no way to report or track the births coming to them that start with a lay-midwife. The IPP developed a tracking form that is completed by the hospital when a delivery complication comes to them. This data is then submitted to the IPP for tracking purposes. Communication has also begun with certified nurse midwives to begin working toward a certification training that will be required for all lay-midwives.

c. Plan for the Coming Year

The PRATS survey monitors utilization of neonatal intensive care services. This information is provided to groups that may influence decisions such as obstetricians closely monitoring pregnancies and ensuring transfers of their patients to facilities with neonatal intensive care units prior to delivery. The data may also influence regional medical centers to consider establishing a neonatal intensive care unit.

The contract with the IPP will be continued with a goal of taking the data collection stage to developing next steps regarding hospital policy on VBAC, education of lay-midwives in a more collegial method and public awareness about the options for delivery if you are at-risk for problematic delivery. The plan for the next year will be finalized in August of 2005.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	80.6	80.7	80.8	83	84
Annual Indicator	80.9	81.9	82.1	81.3	
Numerator	15983	15807	16710	17091	
Denominator	19761	19309	20362	21012	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	86	87	88	88

Notes - 2002

Data for 2002 not available, but will be available by November of 2003.

Notes - 2003

Data re based on records with known data for prenatal care and are for Idaho resident births.

Notes - 2004

Data from Idaho birth certificate data available due to revisions in birth certificate for 2004. Data will be available September 2005.

a. Last Year's Accomplishments

During CY 2004, 9,367 women received counseling and were tested for pregnancy. 1,938 of the 9,367 tests were positive with these women receiving additional counseling and referrals. Counseling for pregnant women includes referral for prenatal care and Medicaid to encourage early prenatal care. All women are screened for the possibility of tobacco use, substance and alcohol abuse, chemical exposure, and nutrition. Referrals for assistance are provided as indicated.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Reproductive Health Program will provide pregnancy testing and referral for prenatal care.			X	
2. Pregnancy Risk Assessment Tracking System.				X
3. The WIC program will provide nutritional counseling and information on other pregnancy risk factors.			X	
4. The Idaho CareLine will provide referrals for prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program participated in the Medicaid program to provide information to be used to create Senate Bill 1140 which would have expanded Medicaid services to families who do not have access to family planning services. Increased access to family planning services allows women to successfully plan their pregnancies and seek earlier prenatal care. The bill was unfortunately defeated in the House Health and Welfare committee during the 2005 legislative session.

c. Plan for the Coming Year

The Reproductive Health Program will continue to work with the Medicaid program to provide further information for a Medicaid demonstration waiver. Reproductive health clinics will continue to provide access to pregnancy testing and counseling in order to promote early access to prenatal care. Program focus will continue to center on developing and sustaining partnerships to ensure expanded services and a more extensive referral base.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Proportion of all pregnancies seen in Reproductive Health Clinics that are unintended*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	70	69.9	69.8	55	55
Annual Indicator	61.8	60.3	60.5	66.7	69.3
Numerator	1921	2122	2208	1503	1859
Denominator	3109	3519	3652	2254	2683
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	55	55	55

a. Last Year's Accomplishments

In CY04, the Idaho Reproductive Health Program continued to expand services by partnering with community health centers in the Twin Falls, Lava Hot Springs, and Downey areas. This collaboration resulted in an additional 857 clients being seen in Idaho's family planning clinics. A total of 290 pap smears were performed in the community health center setting with 5 abnormal results receiving appropriate follow up and intervention. Statewide cervical cancer screening indicates a slight decrease in abnormal pap smear results from 5% to 4.5% of the total tests performed. In CY04, 17,833 pap smears were performed statewide with 803 abnormal results receiving consistent counseling, follow up and intervention. State family planning staff annually monitors cervical screening follow up on abnormal results.

In order to serve populations in remote areas of Idaho, a new clinic was established in Mackay, Idaho located in Custer County. The family planning needs of the 1,455 residents of Custer County between the ages of 15-44 are now served by two clinics managed by District VII Health Department. Travel limitations in this remote area make this clinic a valuable service for local residents.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1.				
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Mobile van service previously provided by District 1 have been discontinued due to funding. The district continues to maintain all previously established outlying clinics in order to provide accessible health care. District 1 maintains a partnership with the Drury clinic, a community health center, which offers primary care services to low income residents.

District 3 continues to expand services at the Farmway Village Migrant camp near Caldwell, Idaho with a newly renovated clinic and extended scheduled provider hours. Expanded outreach services at this site during CY05, include monthly seminars with topics such as breast and cervical cancer, contraception choices, domestic violence and abstinence and parental involvement in reproductive health.

District 6 continues to collaborate with Idaho State University, Department of Medical Anthropology, to provide culturally appropriate care for the Hispanic population in American Falls, Idaho. Clinic hours have now been expanded to include Saturday hours with clinicians currently volunteering their time to staff this weekend clinic. Extended hours have increased the number of individuals seeking care at this clinic site.

c. Plan for the Coming Year

Reproductive Health Program will continue to provide services through contracts with the seven health districts and the current agreements with Community Health Clinics. Following success with the existing collaborative partnerships, the program will continue to seek new organizations willing to provide family planning services or function as referral options. Program services will continue to monitor the requests of providers and develop educational materials to serve current cultural needs. Programs will remain in place which support difficult to reach populations such as in the juvenile detention centers, migrant communities and teen support groups.

The state MCH program will continue to focus on providing comprehensive reproductive health services including abstinence education, counseling and testing for sexually transmitted infections and barrier options to prevent STIs for those that choose to be sexually active. This State Performance Measure is being replaced with a measure that more directly reflects state priority number 4 and 8. The new state performance measure is SPM 3, the percent of 9th - 12th grade students that report having engaged in sexual intercourse. The state priorities related to this measure are adolescents engaging in high risk behaviors leading to unintended pregnancy and sexually transmitted infections.

State Performance Measure 2: *Percent of positive pregnancy tests in Reproductive Health program participants of less than 20 years old*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11.8	11.7	11.6	8	5.5
Annual Indicator	8.9	9.0	8.8	5.7	6.0
Numerator	983	1037	1052	618	498
Denominator	11081	11508	11903	10777	8239
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	4.5	4	3.5	3

a. Last Year's Accomplishments

8,239 teens, aged 19 and under received care in the Reproductive Health Program clinics during CY 2004. The teen pregnancy rate in CY 2003 remained stable at 45.8/1000 which is a slight increase from 45.3/1000 in 2002. Reproductive Health Clinics continue to encourage abstinence as well as parental involvement in the clinic setting as well as during outreach activities.

District I was host to an educational seminar educating health care providers about identification, management, and reporting of sexual coercion. Identification and management of sexual coercion was the focus of course content.

District Two collaborated with Lewis - Clark State College to perform a clinic survey to determine the extent that their adolescent clients involve their parents in their reproductive health care. Follow up surveys were also completed to determine the effect that counseling has on convincing teens to include parents. Survey results showed that 35% of surveyed adolescent females notified parents of care received in the clinic with no increase in parents notified on the return visit despite counseling done by clinic staff.

At the beginning of FY 2005, District IV obtained the services of a full time Teen/Male Health Educator to focus on providing education and counseling services to adolescents in environments primarily outside of the clinic setting. Regular education is held in both formal and informal groups at the Boy's and Girl's Club, Ada County juvenile detention centers and local Drug treatment programs. She has successfully formed a teen advisory group and has also partnered with other organizations in the community to expand opportunities for further outreach

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program continues to offer comprehensive reproductive health services to women throughout Idaho through contracts with public health districts. The District agencies are currently exploring ways to reach more low income women and partner with other organizations that serve this population. Delegates have been encouraged to coordinate with existing services and support the development of needed services with agencies serving high risk and potentially underserved populations for reproductive health care.

Some examples include: Health District I has supported development of a mobile van which serves the low income uninsured population in frontier communities in North Idaho. Health District II continues to offer a clinic for the uninsured that is located in the Health district in Lewiston. Clinics are held in the evenings and staff work to assure family planning and primary care needs of women are met. District III, in Caldwell, has been providing services on site to Farmway and Chula Vista Migrant camps.

Training was completed in Post Falls, Idaho to identify, manage and report sexual coercion.

Information was distributed to delegate providers from the Council on Domestic Violence and Victim's Assistance with all sites having protocol in place to screen and assist victims of domestic violence.

c. Plan for the Coming Year

The Reproductive Health Program will continue to identify needs in the communities to provide outreach services and education. Clinics will continue to coordinate services with other agencies to provide education about abstinence and healthy lifestyle choices for all adolescent clients and outreach contacts. Decreased public education funding in some areas of the State have caused some health education classes to be unavailable for teens within the school system. Districts will continue to evaluate health programs remaining and ensure education programs continue to meet the needs of the communities' teen population. Collaboration with the Governor's Council on Adolescent Pregnancy Prevention will be encouraged within the Health Districts in order to provide support and education regarding abstinence for teen clients.

Continued support for the Teen/Male Health educator in Central District Health is planned for the next year with hopes to encourage expansion to other areas of the State. Programs identifying and educating high risk teen populations will also continue to be a primary focus for Health Districts providing outreach activities.

The state MCH program will continue to focus on providing comprehensive reproductive health services including abstinence education, counseling and testing for sexually transmitted infections and barrier options to prevent STIs for those that choose to be sexually active. This State Performance Measure is being replaced with a measure that more directly reflects state priority number 4 and 8. The new state performance measure is SPM 3, the percent of 9th - 12th grade students that report having engaged in sexual intercourse. The state priorities related to this measure are adolescents engaging in high risk behaviors leading to unintended

pregnancy and sexually transmitted infections.

State Performance Measure 3: *Use of the Idaho CareLine as a clearinghouse (information/referral service) of information for non-health related children's social and developmental services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6200	8000	8500	8500	10000
Annual Indicator	13719				
Numerator		8514	8254	9500	8622
Denominator		1	1	1	1
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11000	11500	12000	12500	13000

a. Last Year's Accomplishments

Continued development and implementation of the 211 system for statewide use. Monitored calls by call type to evaluate the volume MCH related calls.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 211 service is operational statewide on all "land lines." Six wireless service providers have also implemented the 211 service for their customers [AT&T, Edge, Cricket, Nextel, Inland, and Sprint PCS (most areas)]. The remaining cell phone companies plan to implement the 211 service in the near future.

c. Plan for the Coming Year

Finalize implementation of the 211 service through all wireless phone service providers statewide. Careline is fully implemented statewide and is a successful enabling service support for Idaho's MCH population. This State Performance Measure will be discontinued.

State Performance Measure 4: *Percent of child deaths reviewed by the Idaho Child Mortality Review Team*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	41.1	50.2	NaN	NaN	NaN
Numerator	81	102	0	0	0
Denominator	197	203	0	0	0
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

The Child Mortality Team is just getting the cases together for 2001. They review two years out. Information will be included in next year's grant.

Notes - 2003

The Idaho Child Mortality Review Team has been disbanded. A summary of their 5 years of work will be developed as a final document produced by the team. Essentially the first few years of reviews idenfitied areas for improvement and as such recommendations were made. In the most recent year or two, the team believed they were basically reviewing similar types of deaths and that recommendations were just being repeated.

The manner in which the data was being reported in 1999 compared to 2000 and 2001 is the reason the rate of review had declined. All the deaths are reviewed by a subcommittee of the team, but only those that are believed to have been preventable are reviewed in detail by the entire team. These preventable deaths, such as homicide, suicide, and SIDS, were the only ones reported as reviewed in 2000 and 2001. The objective is still correct in the sense that 100% of all those eligible for review were in fact reviewed.

This measure will be replaced next year following completion of the 5 year needs assessment.

Notes - 2004

The Idaho Child Mortality Review Team has been disbanded. A summary of their 5 years of work will be developed as a final document produced by the team. Essentially the first few years of reviews idenfitied areas for improvement and as such recommendations were made. In the most recent year or two, the team believed they were basically reviewing similar types of deaths and that recommendations were just being repeated.

The manner in which the data was being reported in 1999 compared to 2000 and 2001 is the reason the rate of review had declined. All the deaths are reviewed by a subcommittee of the team, but only those that are believed to have been preventable are reviewed in detail by the entire team. These preventable deaths, such as homicide, suicide, and SIDS, were the only ones reported as reviewed in 2000 and 2001. The objective is still correct in the sense that 100% of all those eligible for review were in fact reviewed.

This measure will be replaced next year following completion of the 5 year needs assessment.

a. Last Year's Accomplishments

The Child Mortality review team has been disbanded and will no longer be reviewing child deaths in Idaho.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

No plans to reimplement a Child Mortality Review Team at this time.

c. Plan for the Coming Year

No plans to reimplement a Child Mortality Review Team at this time. This state performance measure will be discontinued.

State Performance Measure 5: *Doses of hepatitis A vaccine administered to children at*

kindergarten entry

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3000	10000	15000	23000	25000
Annual Indicator	4185	12,697.0	17,944.0	16,971.0	17,130.0
Numerator		12697	17944	16971	17130
Denominator		1	1	1	1
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27000	29000	32000	35000	38000

Notes - 2002

A suggestion was made during the block grant review that we consider using an immunization rate for hepatitis A rather than simply reporting doses administered. CDC's national immunization survey does not include hepatitis A, so we have no practical way of determining a rate at this time. We will re-evaluate the value of this measure and may delete it from next year's application.

a. Last Year's Accomplishments

The Immunization Program provided free vaccines to district health departments and private providers for the provision of immunizations to children, including Hepatitis A. This activity combined with those described in the annual plan, did have a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). The most recent National Immunization Program Survey revealed that Idaho's immunization rate (4:3:1) is 84.0%
Hepatitis A vaccine is recommended for Idaho children, but not required. One of the focus areas for the Immunization Program quality assurance reviews over the past year has been to educate providers on the importance of administering the Hepatitis A vaccine. Idaho schools are gearing up for getting kids enrolled for the new school year and up-to-date vaccine records are part of the enrollment process. While Hep A is not required, the state program is working with schools around the state to ensure they recognize the value of the vaccine and encourage parents of their students to consider it.

A major focus of the Immunization Program this past year has been increased provider education. These are regional conferences held throughout the state, focused on increasing immunization awareness, administration and storage of immunizations, as well as how to talk to parents about the importance of immunizations. The Immunization program continues to grow annually making education even more imperative. Site visits were conducted at nearly all VFC provider offices throughout the state. These visits are focused on working directly with the clinic staff to make sure they are following the 17 Standards of Immunization Practices. The program provides technical assistance when necessary. . The Program also continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services.

This includes screening every WIC child's immunization record to verify they are up-to-date.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program will continue to provide vaccines to all public and private providers in the state. The program will work directly with these providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.
The Immunization Program also worked with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program worked closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program focus areas included: parent education; provider education; reminder/recall; review and assessment of WIC clients

Local events will be taking place over the next several weeks as part of the back to school get kids up to date effort. Quality assurance reviews have continued. Planning for QAR visits to determine focus areas for the site reviews for coming year is underway. August is national immunization month.
Finally, the Idaho school and daycare laws to require a 2nd dose of MMR and a 5th dose of DTaP were approved. This process will required the approval by the Board of Health and Welfare and the Idaho legislature prior to full implementation.

c. Plan for the Coming Year

The Immunization Program will continue to work hard to provide vaccines to all public and private providers in the state free of charge for all children 0-18 years of age. The program will work directly with these providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.

The Immunization Program will continue to work with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program will continue to work closely with the WIC program to screen

clients for immunization status and refer those not up to date to their health care provider. Finally, the program will develop a plan for working more directly with parents empowering them to take charge of their child's immunization status. In addition, the program will begin working with Medicaid to identify barriers to immunizations within this distinct population. The development of a Medicaid/Immunization linkage is currently being discussed.

During FY 2006, the Immunization Program will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will maintain a registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series.

Additionally, during FY 2006, the Immunization Program will continue a population-based implementation program to increase hepatitis A immunizations and will include implementation of Varicella surveillance and population based immunizations by (1) targeting children according to ACIP recommendations and (2) providing the vaccine at no cost as part of its general statewide distribution.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program will continue to conduct or contract for activities in four major areas: (1) parent education; (2) provider education; (3) reminder/recall; and (4) review and assessment of WIC clients.

Immunizations continue to be a high priority for Idaho. One area that was recently identified as a significant disparity is the immunization rate of Medicaid covered children. In response to priority number 9, Systems Development, State MCH will be working with Medicaid, WIC, health care professionals and families to create a system collaborative system to ensure the immunization rate of Medicaid children is consistent or greater than that of all children combined. The new measure is SPM 6, the percent of Medicaid and SCHIP children who are fully immunized by age 2.

State Performance Measure 6: *Percent of children age 5 years who are caries-free in their primary teeth (have no decayed, missing or filled teeth due to tooth decay)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	N/A	N/A	37	37	30
Annual Indicator			53.6	34.2	39.1
Numerator			9995	6367	279
Denominator			18647	18628	713
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	50	52	54	56	58

Notes - 2004

Data is from a survey of all kindergarten classes in Idaho Falls school district # 91. State representative data for children age 5 years will be available in 2005 from Idaho State Smile Survey of kindergarten students and in 2006 from Head Start Smile Survey.

a. Last Year's Accomplishments

During 2004, $90,000 in Title V MCH Block Grant funds were again divided equally among the seven Health Districts to provide screening and referral, education and fluoride varnish to low-income, high risk children. Early childhood caries prevention (ECC) projects were conducted by dental hygienists employed by the Districts and targeted WIC clients, Head Start children, and those who are Medicaid/CHIP eligible. During 2004, a total of 10,317 children children received preventive dental services through these special project funds, including 2,951 children who received one or more fluoride varnish applications. A total of 6,627 parents, teachers, dental and medical health professionals were served through education and community outreach efforts.

Statewide data on children age 5 years who have experienced dental caries is not available for 2004. A 2004 survey of Idaho Falls School District # 91 kindergarten students found that 39% were caries-free. Among Non-Hispanic children, 42% were caries-free, compared to 25% of Hispanic children.

The State Oral Health Collaborative Systems Grant to integrate oral health with well child checks was not implemented during 2004, even though numerous planning meetings were held with project partners. An extension was requested to allow the project to be implemented in 2005.

The MCH Oral Health Program Manager participated on the Region X Head Start Oral Health Forum planning committee and assembled a 12 member team, the largest out-of-state delegation at the forum. Following the forum, Idaho team members formed a planning committee to convene an Idaho Head Start Oral Health Forum in November 2004. The planning committee was chaired by the MCH Oral Health Program Manager, the Idaho Head Start Association (IHSA) Executive Director and the Idaho Head Start Collaboration Project Director. Meetings, conference calls and a pre-forum survey of local Head Start programs helped develop the forum agenda. MCH and Collaboration Project funds were transferred to IHSA to help support the forum. IHSA applied for and received an ASTDD grant.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

During 2005, the MCH Oral Health Program is again contracting with the District Health Departments to continue the population-based early childhood caries prevention fluoride varnish projects targeted to high risk, low-income children age birth to 5 years. Funding was slightly reduced because a portion of available dollars were redirected to support the 2005 Smile Survey. District projects continue to be built around one or more components of the Framework for Action outlined in the May 2000 Surgeon General's Report and subsequent Call to Action. Fluoride varnish clinics are conducted by dental hygienists employed by the districts and in partnership with volunteer dental hygienists, dental residents, dental hygiene students and a community health center mobile van.

The Idaho Head Start Oral Health Forum was convened November 18-19, 2004. Keynote and plenary sessions identified issues and potential solutions, and were followed by breakout sessions to identify strategies to improve children's oral health and access to care. As a result of the Forum, an Idaho Head Start Oral Health Plan was developed and publicized via the media and articles in the state dental and dental hygiene association newsletters. IHSA hired an assistant executive director to help implement the oral health plan and created a Health Advisory Committee. Preparations are underway to provide regional motivational interview trainings to oral health, WIC and Head Start staff by the end of September 2005. The trainings will include a presentation on best practices related to early childhood caries prevention, disease transmission, and the link between oral health and birth outcomes.

State and district representative data to evaluate the early childhood caries State Performance Measure is being collected as part of the 2005 Idaho State Smile Survey.

The State Oral Health Collaborative Systems (SOHCS) Grant extension was received and the project implemented. A pediatric dentist and a district dental hygienist have provided three trainings to the Family Practice Residency of Idaho faculty, staff and residents on oral health risk assessment, screening, ECC prevention and fluoride varnish application. June and September chart reviews, along with Medicaid data, will be used to evaluate the success of the project. Training has also been provided to nurses in one health district to provide fluoride varnish to children as part of the immunization visit. This second district has also developed materials adapted from the Connecticut Open Wide curriculum in preparation for trainings that will be provided to physicians by community dentists.

Idaho will submit an application to send a team to the CHCS Purchasing Institute Best Practices for Oral Health Access.

c. Plan for the Coming Year

In 2006, MCH funding to the Districts for ECC prevention will be continued. An Idaho Head Start Smile Survey is planned to serve as a baseline for evaluation of outcomes from implementation of the Idaho Head Start Oral Health Plan. Community outreach using the new AAP Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals is also planned. In addition, agenda time slots have been reserved for oral presentations at the February 2006 Idaho Perinatal Project Mid-Winter Conference. Plans are to build on the SOHCS project success and continue efforts to integrate oral health with primary medical care.

This measure will continue to be evaluated by the State MCH program, but may be

discontinued as one of the state performance measures reported in the block grant application. Children's dental health continues to be a priority for the state of Idaho, but an area involving dental health needing immediate attention that was reinforced by the needs assessment is pregnant women accessing dental care during pregnancy. This is listed as state priority number 7. The new SPM is measure 5, percent of pregnant women who received dental care during pregnancy.

State Performance Measure 7: *Percent of investigations completed on children with elevated blood lead levels*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	38	34	18	22	10
Denominator	38	34	18	22	10
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Information is for Calendar Year.

a. Last Year's Accomplishments

There were 10 reported cases of elevated blood lead levels in children 0-18 years of age, and all 10 were investigated to determine possible causes and recommendations were provided to families on methods to prevent future exposure. Elevated blood lead is required to be reported within 3 days in Idaho.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The district health department epidemiologists investigated all children with elevated blood lead levels and will continue to do so.

c. Plan for the Coming Year

The Office of Epidemiology and Food Protection will continue to collect elevated blood lead level reports as part of its surveillance activities. Efforts will be made to ensure investigation of such elevated results on children.

After several statewide and regional studies, it has been determined that Idaho does not see significant lead levels in children. With the exception of a superfund site in north Idaho, high blood levels in children are almost non-existent. This state performance measure will be discontinued.

State Performance Measure 8: *Percent of deaths attributed to SIDS that are autopsied*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95	100	100	100	100
Annual Indicator	95.0	100.0	100.0	94.7	
Numerator	19	15	13	18	
Denominator	20	15	13	19	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

The Bureau of Health Policy and Vital Statistics has not finalized this information yet. Will be made available as soon as possible.

Notes - 2003

Percent of deaths to Idaho resident babies attributed to SIDS that are autopsied. Note: some SIDS deaths may occur out of state.

Notes - 2004

Idaho mortality database not finalized. Data will be available September 2005.

a. Last Year's Accomplishments

MCH will continue to monitor the percent of SIDS deaths that are autopsied.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH will continue to monitor the percent of SIDS deaths that are autopsied.

c. Plan for the Coming Year

MCH will continue to monitor the percent of SIDS deaths that are autopsied.

The vast majority of SIDS deaths are being autopsied. Investigating SIDS deaths was noted as a priority area of the Child Mortality Review Team. The team has been disbanded and the data indicates Idaho is achieving it's goal of having 100% of SIDS deaths investigated. This state performance measure will be discontinued.

State Performance Measure 9: *Percent of CHIP eligible children who are enrolled in the program*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	47.5	50	50	50
Annual Indicator	69.3	41.2	38.6	41.0	62.6

Numerator	13866	11940	11197	11885	18165
Denominator	20000	29000	29000	29000	29000
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	70	75	80	85

Notes - 2002

The denominator is an estimate by the Urban Institute.

Notes - 2003

The denominator is an estimate by the Urban Institute.

Notes - 2004

The denominator is an estimate by the Urban Institute.

a. Last Year's Accomplishments

Promotion of the toll-free information and referral telephone service, CareLine, to the MCH, Infant Toddler and Medicaid populations (including CHIP referrals). The CSHP program also encourages CHIP application for clients wishing to receive services from the program.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Investigate the feasibility of providing regional dental clinics for Medicaid and CHIP children.				**X**
2. Increase the awareness of families about CHIP and Medicaid coverage through CSHP.				**X**
3. Idaho CareLine will continue to refer callers to Medicaid for CHIP enrollment, when appropriate.		**X**		
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

CSHP continues to work, through its clinic network and parent group, to increase the awareness of families about CHIP and Medicaid coverage.

CareLine continued to refer callers to Medicaid for CHIP enrollment, when appropriate.

c. Plan for the Coming Year

CSHP continues to work, through its clinic network and parent group, to increase the awareness of families about CHIP and Medicaid coverage.

CareLine will continue to refer callers to Medicaid for CHIP enrollment, when appropriate.

Efforts to influence this measure has met variable success. One major barrier that arose a few years ago was the state legislature's request to not promote Medicaid and SCHIP availability. The driving factor was by "promoting" services for children, parents actually learned they too qualified for Medicaid and placed substantial strain on the state match for the Medicaid budget. In addition, some recent events would make one question the state's perception of insurance need for low income children. While we have always estimated the number of eligible children, Medicaid recently implement an option to cover children from 150% of the Federal Poverty Level up to 185%. In anticipation of high demand, there was a limited open enrollment period. The results were a very low response. A second effort was made to actually promote the program at the start of the school year. That too yielded results that did not come close to meeting the enrollment cap placed on the program. Currently the program is continually open for enrollment.

This performance measure will be discontinued.

E. OTHER PROGRAM ACTIVITIES

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and management.

The CSHP Program will continue to provide biannual regional PKU clinics in Boise, Idaho Falls, and Spokane, Washington. Idaho has made the decision to consolidate PKU services under one physician in effort to provide consistent care from birth through 18. Dr. Ron Scott will discontinue staffing Idaho clinics during the summer of 2005 and Dr. Cary Harding from Oregon Health and Science University will be taking his place. Families receive initial consultation from OHSU and Dr. Harding already comes to Idaho to see children with other metabolic disorders.

The MCH research analyst, Greg Seganos, and the MCH special Projects Coordinator, Traci Berreth, have recently completed the publication of the Bureau of Clinical and Preventive Services outcome performance measures. This document will be updated quarterly and will provide a method for the MCH programs to monitor performance on a statewide basis as well as provide information to the Department's administration in regard to the Bureau's contribution to the Department's goal of improving health status.

The Idaho Fit Kids Project is a year long pilot project focusing on the use of BMI as a predictor of risk for overweight in children and providing families with helpful tips on health. The Division of Health contracted with the District Health Departments in the state to provide training to pediatrician and

family practice offices in their service area. The trainings include factual information on BMI, ideas for incorporating BMI into practice and how to provide parents with guidance related to their child's healthy growth.
Each Health District has been contracted to provide up to 25 trainings between March 1, 2005 and October 31, 2005. The Division of Health provided training to the Health Districts regarding this project in January 2005.

Through the trainings provided by the Health Districts, physician offices will receive "Idaho Fit Kids" handouts for patients, CDC growth grids, and a card for families to mail to the Department of Health and Welfare if they would like to receive more information related to healthy growth. The families who return the request for information card will receive a series of 6 newsletters in the mail from the Division of Health. The newsletters will contain tips on eating healthy and activity.

To date, the Health Districts have trained over 30 physician offices in the state.

Evaluation will take place in January 2006 and will include:

1. Chart review of physician offices which received training to measure whether or not BMI was assessed.

2. A written survey will be mailed to families who requested more information for the purpose of determining if they found the information helpful.

3. Physician offices will be asked to complete a brief survey during January 2006 related to the project.

The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 34,190 children grades 1-6 in 2004. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 51,747.

F. TECHNICAL ASSISTANCE

The Idaho Oral Health Program may request technical assistance to support the prenatal oral health project that is currently in the planning stages for implementation in FY 2006.

The goal of the project is to integrate oral health with prenatal care. The target population is pregnant women, particularly those served through the Medicaid Program. The Idaho Medicaid Program pays for approximately 40% of all deliveries. Efforts will be made to engage both medical and dental care providers in the effort. Project partners will include the Medicaid Healthy Connections Program, the District WIC and Oral Health Programs, as well as representatives of professional and community organizations with an interest in maternal and child health.

Project objectives are to increase awareness of the link between oral health and birth outcomes and increase access to periodontal care that can improve pregnancy outcomes. Medicaid data on dental access and costs associated with deliveries and preterm births will serve as a baseline for project evaluation.

Plans are to bring together key stakeholders for a brainstorming session to present the project proposal, get input, and form a state leadership team. If a technical assistance request is submitted, it will be to bring in a consultant to participate in the brainstorming session, advise the leadership team, and to provide continuing education for project partners on the science linking oral health to birth outcomes and the safety of providing dental services during pregnancy. We anticipate both state and district level trainings could require technical assistance.

V. BUDGET NARRATIVE

A. EXPENDITURES

Annual Expenditures

For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and related notes.

Funds used for state match during federal fiscal year 2004 are from the Immunization Program. State general fund in the amount of $1,805,000 were used to purchase vaccine for children. This funding commitment allows the state to maintain universal status where all children regardless of income or insurance status have access to free vaccine. The other portion of MCH grant match comes from local Immunization Program funds in the amount of $904,636. These funds are used for immunization education and outreach and for conducting local immunization clinics.

The expenditures in FFY 04' that were directed to Pregnant Women including 25% of the MCH administrative budget ($31,265), Pregnancy Risk Assessment Tracking system ($21,780), 25% of the Office of Epidemiology and Food Protection MCH budget ($63,704), 20% of the Reproductive Health MCH budget ($158,979), and 25% of the Idaho CareLine MCH budget ($6,641).

Funds used in FFY 04' for Infants < 1 Year Old included 25% of the MCH administrative budget ($31,265), 25% of the Office of Epidemiology and Food Protection MCH budget ($63,704), 25% of the Idaho CareLine MCH budget ($6,641), 50% of the Immunization Program state and local funds used for block grant match ($1,354,818), funds to cover SIDS autopsies ($3,029), newborn hearing screening ($8,310), and 25% of the MCH funds spent by the Idaho Child Mortality Review Team ($89). The Child Mortality Review Team was phased out at the beginning of FFY 04'.

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($31,265), 25% of the Office of Epidemiology and Food Protection MCH budget ($63,704), 25% of the Idaho CareLine MCH budget ($6,641), 50% of the Immunization Program state and local funds used for block grant match ($1,354,818), the Oral Health Program ($334,473), 40% of the MCH budget for Reproductive Health ($317,959), 75% of the MCH funds for the Child Mortality Review Team ($266 - phased out), and Suicide Prevention ($11,928).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget ($31,265), 25% of the Office of Epidemiology and Food Protection MCH budget ($63,704), 25% of the Idaho CareLine MCH budget ($6,641), the Genetics Program ($150,487) and the Children's Special Health Program ($1,545,434).

40% or $317,959 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age. And $335,714 in indirects was included in expenditures for the Administrative budget.

FFY 04' expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the Genetics Program budget ($135,438), the Reproductive Health Program Budget ($794,897) and the Children's Special Health Program budget ($1,545,434). The only program included under enabling services was the Idaho CareLine ($26,562). Programs included in the Population-Based Services category were Oral Health ($334,473), Immunizations ($2,709,636 - state and local match), Newborn Hearing Screening ($8,310), Child Mortality Review Team ($355 -phased out), and Suicide Prevention ($11,928). Programs included under infrastructure Building Services included: MCH Administration ($125,061), Pregnancy Risk Assessment Tracking System ($21,780), Office of Epidemiology and Food Protection ($254,814), 10% of the Genetics Program ($15,049), SIDS Autopsies ($3,029), and the indirect budget ($355,714).

Total reported MCH expenditures for Idaho during FFY 04' are $6,322,485.

B. BUDGET

Budget Narrative

To meet the match requirement the state will be utilizing $1,800,000 in state general fund and $729,878 in local funds.

The priority areas for Idaho are children with special health care needs, reproductive health for young women, oral health of children and women of child bearing age, epidemiology services and genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. In fact, those two programs alone account for 39% of the block grant funds. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Epidemiology.

An area we had focused additional funding on was Idaho's Pregnancy Risk Assessment Survey. Data from previous years provided an overview of perinatal issues statewide, but by increasing the sample size we are now able to identify trends in specific areas of the state.

A project that was funded last year for the first time was a perinatal project. The purpose of the project was to establish a system for collecting data on outcomes of lay midwife deliveries. Hospitals report stories of pregnant women and/or their newborns arriving at the emergency room of the local hospital seeking care in an emergency state after a failed home delivery, but there is currently no data to determine the frequency of this occurrence. $40,000 dollars had been allocated for this project last year and $40,000 has been allocated to continue the project in FFY 06'. To date a good working relationship has been established between Idaho Perinatal Project team and midwives in the state. One goal of the contract is to increase the level of education and training for midwives in the state. Questions will be added to a lay midwife survey about back up and relationships with hospital and physicians in their areas. A survey of complications occurring during home deliveries has been collected and the results are currently being analyzed. A radio spot has been developed and will be airing soon that refers pregnant women to Idaho's CareLine for referrals to appropriate perinatal health care providers and to get a list of 10 questions to ask before delivery at home. Depending on the results of the birth complications survey, the Project may move forward with seeking legislation to ensure the best possible birth outcomes for all infants born in Idaho.

Another project slated to begin this coming grant period is around improving birth outcomes and dental health of new mothers and their infants and young children. This project will target primary care providers, dentists and others professionals in the community to increase awareness on the importance of a dental visit during the second trimester. The project will also work toward improving the awareness among females of reproductive age about the importance of dental care during pregnancy. $50,000 has been allocated to this project, and it will be administered through the oral health program.

A project that was implemented this past year that will continue into the coming year is to increase utilization of body mass index among pediatricians and other health care professionals caring for young children and adolescents. This project's budget is approximately $110,000. In addition to education of primary care providers, families with young children have the opportunity to enroll in the project and will receive mailings every two weeks with ideas for things like food selection and exercise options for the entire family. The Idaho WIC program has been managing this project.

The above three mentioned projects are directly intended to create systems change. This allows the federal MCH dollars to be invested for only a short period of time with long term benefits to the overall system caring for pregnant women and children.

One area that the State has made progress on over the past year is transitioning Idaho's Children Special Health Program away from being primarily an insurance plan to focusing on care coordination

for the uninsured and ensuring reasonable access to specialty care throughout the state. This is the first step to a longer term plan of ensuring access to care and health care system navigation for all families of children with special health care needs, not just those covered by Idaho's current program. In past years, expenditures in this category have always by far exceeded the amount allocated. The mechanism by which this was allowed to occur was as follows: First was utilizing unspent funds from previous grant awards, and secondly by reducing funding in other high priority MCH programs/activities. We believe that FFY 05 expenditures for the CSHP will be close to staying within budget, allowing the program to plan for projects to address other areas of need. The following year we expect to actually maintain expenditures within budget. This transition was a very difficult task, but one that we have recognized as being necessary for the past few years. Work is currently underway with various agencies, organizations and policy makers to develop the future role for MCH and CSHP.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.